

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 years, 1 month, 4 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 2 years, 1 month, 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Calvert
 City or town Solomons
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

John Mitchell Abbott

3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Blanche Allen Abbott
 6.(c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) September 7, 1886

8. AGE: Years 61 Months 7 Days 24 If less than one day _____ hrs. _____ min.

9. Birthplace Maryland
 (Town, county, and state)

10. Usual occupation barber
 11. Industry or business own business

12. Name Jabetz Abbott
 13. Birthplace Maryland

14. Maiden name Alice Files
 15. Birthplace Baltimore, Md.

16. Informant Hospital Records
 Address Catonsville 28, Md.

17. Burial Date thereof May 3, 1948
 (Burial, cremation, or removal - Which?) (month) (day) (year)

Cemetery or crematory Solomons M. E. Ch.
 Location Solomons, Ind.

18. Funeral director A. P. Harrison & Son
 Address Mutual Ind.

19. 5-3 19 48 N. W. Evans
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 19 48 at 7:45 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 27 19 46 to May 1 19 48
 and that I last saw him alive on May 1 19 48

Immediate cause of death Coronary sclerosis DURATION Indef.

Due to Arteriosclerotic Heart Disease Indef.

Due to Generalized arteriosclerosis Indef.

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Isadore Tuerk, M.D. M. D. or other

Catonsville 28, Md.

Address _____ Date signed 5/1/48

RECEIVED

MAY 4 '48

BALTIMORE COUNTY
HEALTH DEPT. & CITY

RECEIVED

MAY 6 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 41

04652

170C

1. PLACE OF DEATH:

County Baltimore
City or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution or street address where death occurred:

Flagship Rd + Shipway.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Baltimore
City or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)

Street No. 15 Leeway
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Marilyn Alpigini

3. (b) Social Security Number

4. Sex

F.

5. Color or race

W.

6.(a) Single, married, widowed, or divorced

S.

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, y)

February 8, 1944

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

431hrs.min.

9. Birthplace

Baltimore, Md.
(Town, county, and state)

10. Usual occupation

none

11. Industry or business

FATHER

12. Name

David E. Alpigini

13. Birthplace

Philadelphia, Pa.

MOTHER

14. Maiden name

Mary E. Staley

15. Birthplace

Harrisburg, Pa.

16. Informant

David E. Alpigini

Address

15 Leeway, Dundalk.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

May 11, 1948
(month) (day) (year)

Cemetery or crematory

Sacred Heart

Location

German Hill Road, Balto. Co.

18. Funeral director

Roland L. Fisher

Address

2112 Dundalk Ave.

19. May 10

(Date rec'd by registrar)

19 48

William M. Kelly Jr.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 9th

19

48

21

322p

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw h

alive on

19

Immediate cause of death

Fracture of Skull - Parietal R

DURATION

Due to

Fracture Rt. Collar Bone

Due to

Fracture Left Femur

Due to

Stunt by Automobile

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Accident

Date of

5/9/48

Where did injury occur?

Dundalk - rr - Balto Md

(City or town)

County

(State)

Injured at home, farm, industry, public place (where?)

Street - Public

Means of injury

Stunt by Automobile

Injured at work?

No

23. SIGNATURE

W. M. Beaver MD

Address

Dundalk - rr - Balto Co Md

Date signed

5/9/48

RECEIVED

MAY 12 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Baltimore
City or town Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 1/2 yrs.
Hospital, institution, or street address where death occurred:
910 C. Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore
City or town Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)
Street No. 910 C. Street
(If rural, give LOCATION)
2.(a) If veteran, name war.

3. (a) FULL NAME

Maude Anderson

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife.

7. Birth date of deceased (mo., day, yr.) Nov. 9, 1887 6.(c) If alive, give age years

8. AGE: Years 60 Months 5 Days 24 If less than one day hrs. min.

9. Birthplace Ohio
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name George J. Benbow
13. Birthplace England

14. Maiden name MARTHA PRICE
15. Birthplace England

16. Informant Mr. Geo. T. Benbow
Address 910 C. St. Sparrows Pt.

17. Removal Date thereof 5/4/48
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Union
Location Steubenville, Ohio

18. Funeral director Wm. J. Tickner & Sons
Address NORTH & Pa. Aves.

19. May 4 - 48 Dawson L. Harbor
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/3/48 at 11 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 6 - 1948 to May 3 - 1948
and that I last saw him alive on May 3 - 1948

Immediate cause of death Cerebro-respiratory failure DURATION 4 days

Due to Diabetes Mellitus complicated by broncho. 10 yrs
pneumonia and 3 wks
pyelonephritis

Other conditions Amputation of legs at upper third of thigh 6 yrs.
(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results. PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

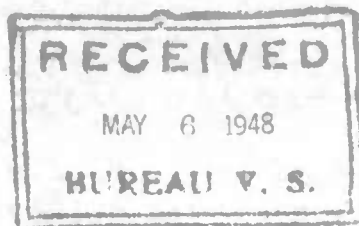
23. SIGNATURE Dawson L. Harbor M. D. or D.D.S.
Address Sparrows Point - 19-Md. Date signed 5/4/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Dawson Farber.
904 C. St.
Sparrows Point.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 44

04653

1310

1. PLACE OF DEATH:

County BaltoCity or town Middle River
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:

Long Hall Nursing HomeHow long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County BaltoCity or town Middle River Route 16
(If outside city or town limits, write RURAL and give nearest town)Street No. 398 A Thompson Blvd
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary A Auld

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

Harry E Auld

7. Birth date of deceased (mo., day, yr.)

Feb 5 1875

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

73323

hrs.

min.

9. Birthplace

Balto Md
(Town, county, and state)

10. Usual occupation

at home

11. Industry or business

FATHER

12. Name

Jacob Weber

13. Birthplace

Md

MOTHER

14. Maiden name

Margaret Hendricks

15. Birthplace

Md

16. Informant

Harry E Auld

Address

398 A Thompson Blvd Route 16 Camp

17.

Burial
(Burial, cremation, or removal, Which?)

Date thereof

June 11 1948
(month) (day) (year)

Cemetery or crematory

Cathedral

Location

Balto Md

18. Funeral director

Ullrich Funeral Home

Address

2008 Orleans St

19.

5/21/48
(Date rec'd by registrar)

19.

AS Medical
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 1948 at 2:15 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 28 1948 to May 28 1948and that I last saw him alive on May 27 1948

Immediate cause of death

Branchio ProlapsiaUrethra

Due to

arterio scleros Hypertension

Due to

chronic interstitial Nephritis

Other conditions

Aquous Pectus

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

injured at work?

23. SIGNATURE

P.P.A. Stevens M.D.

M. D. or other

Address

2878 Harford Rd

Date signed

5-28-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

04654

93d

1. PLACE OF DEATH:

County.....Baltimore.....City or town.....Catonsville.....
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Opitz Nursing Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Md...... County.....Balto......City or town.....Owings Mills.....
(If outside city or town limits, write RURAL and give nearest town)Street No.....Deer Park Rd......
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

MARY MOLLIE BAKER

3. (b) Social Security Number

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widow

6. (b) Name of husband or wife.....William John Baker.....7. Birth date of deceased (mo., day, yr.).....Sept. 11, 1863.....8. AGE: Years.....84..... Months.....8..... Days.....10.....
If less than ann day.....hrs.....min.9. Birthplace.....Va......
(Town, county, and state)10. Usual occupation.....None.....

11. Industry or business.....

12. Name.....John Tolson.....13. Birthplace.....Va......14. Maiden name.....Mary (unknown).....15. Birthplace.....Unknown.....16. Informant.....Mrs. Grace M. Barnes.....Address.....Owings Mills, Md......17. Burial.....Burial..... Date thereof.....5/24/48.....
(Burial, cremation, or removal; which?) (month) (day) (year)Cemetery or crematory.....Loudon Park Cem......Location.....Balto., Md......18. Funeral director.....WM. J. TICKNER & SONS.....Address.....Balto., Md......19. May 22 1948.....V.E. Harry.....
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....May 21,.....48.....5:30 p......21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....May 18.....May 21.....10.....
and that I last saw him alive on.....May 21.....10.....Immediate cause of death.....Chr. Myocarditis.....Due to.....Arterio Sclerosis.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....(City or town).....(County).....(State).....

Injured at home, farm, industry, public place (where?).....

Means of injury.....Injured at work?

23. SIGNATURE.....W. E. Harry.....
Address.....Owings Mills.....

M. D. OF DEATH.....

Date signed.....5/22.....



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH: 5530 Willys Ave
County: Baltimore
City or town: (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: md County: Baltimore
City or town: (If outside city or town limits, write RURAL and give nearest town)
Street No.: 5530 Willys Ave Apt 616
(If rural, give LOCATION)
2(a) If veteran, name war

3. (a) FULL NAME: Thelma R. Baker

3. (b) Social Security Number: 215-04-6677

4. Sex: F 5. Color or race: W 6. (a) Single, married, widowed, or divorced: married

6. (b) Name of husband or wife: Alton Baker

6. (c) It alive, give age: years
7. Birth date of deceased (mo., day, yr.): Aug 7 - 1910

8. AGE: 37 Years 8 Months 26 Days It less than one day: hrs. min.

9. Birthplace: Baltimore md (Town, county, and state)

10. Usual occupation: house wife

11. Industry or business: Charles F. Bell

12. Name: Charles F. Bell

13. Birthplace: Baltimore, md

14. Maiden name: Ella S. Shawbarger

15. Birthplace: Baltimore, md

16. Informant: Mrs. Ella Bell

Address: 5530 Willys Ave

17. (Burial, cremation, or removal, Which?): Burial Date thereof: May 8 - 48 (month) (day) (year)

Cemetery or crematory: Linden Park

Location: Charles P. Towell

18. Funeral director: Charles P. Towell

Address: 2427 Calumondson Ave

19. May 6 1948 A. W. Hedrick Registrar

20. DATE OF DEATH: 5/5/48 1948 at 9:25 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12:15 to 5:15 PM and that I last saw her alive on 5/5/48

Immediate cause of death: CHRONIC GLOM. NEPHRITIS

Due to: CHRONIC TONSILLITIS

Due to: RHEUMATIC PANCREATITIS

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Samuel E. Leonard, Jr. M. D. or other

Address: 1905 W. BALTIMORE Date signed: 5/6/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Mr. Boyerod
Bolt St.

NAME	Mr. Boyerod
ADDRESS	Bolt St.
CITY	
STATE	
ZIP	
DATE	
TIME	
REMARKS	

RECEIVED BY THE
DEPARTMENT OF HEALTH
AND HUMAN SERVICES
ON JULY 1, 1964

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

48a

04656

33

Reg. Dist. No.

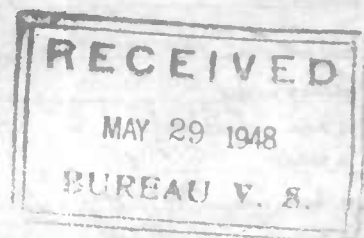
1. PLACE OF DEATH: County..... <u>Baltimore</u> City or town..... <u>Reisterstown</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... <u>45 years</u> Hospital, institution, or street address where death occurred: How long in hospital or institution?.....			2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... <u>Maryland</u> County..... <u>Baltimore</u> City or town..... <u>Reisterstown</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>21 Main St.</u> (If rural, give LOCATION) 2.(a) If veteran, name war.....		
3. (a) FULL NAME <u>Beulah Estelle Barnes</u>			3. (b) Social Security Number		
4. Sex <u>Female</u>			5. Color or race <u>White</u>		
6. (a) Single, married, widowed, or divorced <u>Married</u>			6. (b) Name of husband or wife <u>William L. Barnes</u>		
6. (c) If alive, give age <u>45</u> years			7. Birth date of deceased (mo., day, yr.) <u>Aug. 10, 1902</u>		
8. AGE: Years <u>45</u> Months <u>9</u> Days <u>17</u> If less than one day hrs. min.			9. Birthplace <u>Maryland</u> (Town, county, and state)		
10. Usual occupation <u>Housewife</u>			11. Industry or business		
12. Name <u>Charles D. Grimm</u>			13. Birthplace <u>Md. United States</u>		
14. Maiden name <u>Florence K. Morris</u>			15. Birthplace <u>Md. United States</u>		
16. Informant <u>William L. Barnes</u> Address <u>Pikeville 8, Md.</u>			17. Burial (Burial, cremation, or removal, which?) <u>Burial</u> Date thereof <u>May 30, 48</u> (month) (day) (year) Cemetery or crematory <u>Pleasant Grove</u> Location <u>Baltimore</u>		
18. Funeral director <u>J. F. Elmer, Sons</u> Address <u>Reisterstown Md.</u>			19. 5-25 - 1948 (Date rec'd by registrar) <u>Mary B. Elmer</u> Registrar		
MEDICAL CERTIFICATION					
20. DATE OF DEATH <u>May 27</u> 19 <u>48</u> , at <u>10:30 P.M.</u>					
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>March 15</u> 19 <u>48</u> , to <u>May 27</u> 19 <u>48</u> and that I last saw her alive on <u>May 27, 1948</u>					
Immediate cause of death <u>Cerebral Metastasis</u>					
Due to <u>Carcinoma Cervix</u>					
Other conditions <u>Rheumatoid Heart Disease</u>					
(Include pregnancy within 3 months of death)					
Major findings of operations					
Autopsy results					
PHYSICIAN: Please underline the cause to which death should be charged statistically.					
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of..... Where did injury occur?..... (City or town) (County) (State) Injured at home, farm, industry, public place (where?)..... Means of injury..... Injured at work?.....					
23. SIGNATURE <u>Martin E. Strobel</u> M. D. or other Address <u>Reisterstown, Md.</u> Date signed <u>5/27/48</u>					

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

LOCAL HEALTH DEPARTMENT OF MARYLAND

MEDICAL CERTIFICATION



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:

County BaltimoreCity or town Reisterstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Dover Road-Box 67

How long in hospital or institution?

3. (a) FULL NAME

Janette May Baublitz

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Isaac Baublitz6. (c) If alive, give age 69 years

7. Birth date of

deceased (mo., day, yr.)

April 7, 1880

8. AGE:

Years

Months

Days

If less than one day

68-29

hrs.

min.

9. Birthplace

Betha Balto. Co. Md.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

Abraham Combs

13. Birthplace

Balto. Co. Md.

MOTHER

14. Maiden name

Mary Bailey

15. Birthplace

Balto. Co. Md.

16. Informant

Isaac Baublitz

Address

Box 67 Reisterstown, Md.

17.

(Burial, cremation, or removal, Which?)

Date thereof

May 8, 1948
(month) (day) (year)

Cemetery or crematory

Wood Ridge

Location

Patersonville, Md.

18. Funeral director

Landan M. Brooks

Address

8 parks, Md.

19.

(Date rec'd by registrar)

6/171948A. W. Sedwick

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Reisterstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. Dover Road-Box 67

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 1948 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1-15 1941 to 5-6 1948and that I last saw her alive on 5-5 1948

Immediate cause of death

1- Chronic suppurative otitis media 2- remission 1- wh.2- Pulmonary hemorrhage 2- do.Due to 1- Chronic suppurative otitis media 15-yr?2- Pulmonary fibrosis 17-yr?

Due to

Other conditions Hypertensive & V. Disease 7-yr.

(Include pregnancy within 8 months of death)

Major findings of operations

NONE

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? NONE

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE D. D. Caples, M.D.

M. D. or other

Address Reisterstown, Md. Date signed 5-6-48

CERTIFICATE OF DEATH

1. NAME OF DECEASED (PRINT NAME)

2. SEX (M or F)

3. AGE (Years, Months, Days)

4. DATE OF BIRTH (Month, Day, Year)

5. PLACE OF BIRTH (City, State, Country)

6. OCCUPATION (Print Name)

7. CAUSE OF DEATH (Print Name)

8. MANNER OF DEATH (Print Name)

9. PLACE OF DEATH (Print Name)

10. TIME OF DEATH (Print Name)

11. SIGNATURE OF PHYSICIAN (Print Name)

12. SIGNATURE OF REGISTRAR (Print Name)

13. SIGNATURE OF WITNESS (Print Name)

14. SIGNATURE OF DECEASED (Print Name)

15. SIGNATURE OF SURVIVOR (Print Name)

16. SIGNATURE OF NEXT OF KIN (Print Name)

17. SIGNATURE OF CLERGYMAN (Print Name)

18. SIGNATURE OF CHURCH (Print Name)

19. SIGNATURE OF FUNERAL HOME (Print Name)

20. SIGNATURE OF BURIAL PLACE (Print Name)

21. SIGNATURE OF INTERMENT (Print Name)

22. SIGNATURE OF CREMATION (Print Name)

23. SIGNATURE OF OTHER (Print Name)

24. SIGNATURE OF OTHER (Print Name)

25. SIGNATURE OF OTHER (Print Name)

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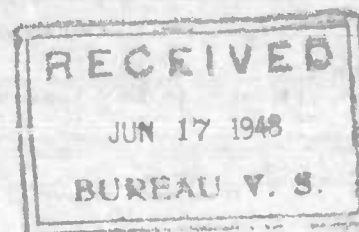
56. SIGNATURE OF OTHER (Print Name)

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Hood Nursing Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State md. County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 438 Rosecroft Terrace
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Grace L. Bauer

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced widow
6.(b) Name of husband or wife Late Conrad Bauer
7. Birth date of deceased (mo., day, yr.) Sept 20, 1871
6.(c) If alive, give age years
8. AGE: Years 76 Months 7 Days 13 If less than one day hrs. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name George Spies
13. Birthplace Germany

MOTHER 14. Maiden name
15. Birthplace Germany

16. Informant Mr. John C. Bauer
Address 438 Rosecroft Terrace

17. Burial Date thereof 5-5-48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Loulon Park
Location 3801 Frederick Rd.

18. Funeral director Harry H. Witzke
Address 4101 Edmondson Ave

19. May 5 19 48 A. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 19 48 at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 44 to May 3 19 48
and that I last saw him alive on April 30 19 48

Immediate cause of death Hypertensive Cardiomyopathy
Cholesterol Nephropathy
Due to multiple

Due to thrombophlebitis of lower extremities

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. H. Sawhead M. D. or other

Address 14 E. Cochrane St Date signed 5/4/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04658

Reg. Dist. No. 35-

1. PLACE OF DEATH

County Baltimore
City or town Parkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Penn. County York
City or town Glen Rock
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Mamie V. Becker

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

James C. Becker

7. Birth date of deceased (mo., day, yr.)

January 13, 1880

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

It less than one day

68

3

23

hrs.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Own home

FATHER

12. Name

Robert Bull

13. Birthplace

Md.

MOTHER

14. Maiden name

Jean Alban

15. Birthplace

Md.

16. Informant

Jesse Becker

Address

Glen Rock Pa.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

May 9, 1948

Cemetery or crematory

Five Grove U.B. Cem.

Location

Parkton, Md. R.D.

18. Funeral director

Jacob Hartenstein

Address

New Freedom Pa.

19. May 7

(Date rec'd by registrar)

1948

Christine J. Burton
Doris Lane Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 6, 1948

at 2:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 6

19 48

to May 6

19 48

and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death

Coronary occlusion
Myocardial infarction

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. M. France

M. D. or other

Address

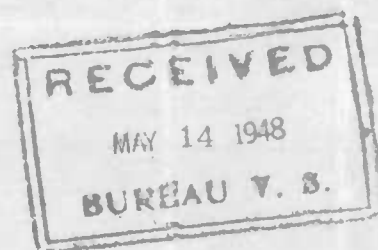
Parkton, Ind.

Date signed 5/6/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:

County BALTO
 City or town 2021 Gwynn Oak Ave
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD CountyCity or town WOODLAWN
 (If outside city or town limits, write RURAL and give nearest town)Street No. 2021 Gwynn Oak Ave
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

J. HARRY BIEMILLER

3. (b) Social Security Number

No

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

MARRIED6. (b) Name of husband or wife MARGARET BIEMILLERNEE SAUNDER

7. Birth date of deceased (mo., day, yr.)

JUL. 6, 1871

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

76929

hrs.

min.

9. Birthplace

BALTO, MD.
 (Town, county, and state)

10. Usual occupation

RETIRED

11. Industry or business

FATHER

12. Name JOHN HENRY BIEMILLER13. Birthplace GERMANY

MOTHER

14. Maiden name CAROLINE PREISZ15. Birthplace MD.16. Informant MRS. MARGARET BIEMILLER (Wife)Address 2021 Gwynn Oak Ave17. BURIAL
 (Burial, cremation, or removal. Which?)Date thereof MAY 7, 1948
 (month) (day) (year)

Cemetery or crematory

LOUDON PARK

Location

BALTO, MD

18. Funeral director

Wm T. TUCKER & Sons

Address

BALTO, MD

19.

may 7 1948

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/5 1948 at 4 06 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1st 1947 to 5/5/48 19and that I last saw him alive on 5/5/48 19Immediate cause of death Myocardial Infarction

DURATION

Due to

Coronary Disease

Due to

Decomposition

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Wm T. Tucker

M. D. or other

Address

3033 W KORTZ

Date signed

5/6/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

160C

04660

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:

County Baltimore
City or town Abtutum
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore
City or town Abtutum
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1331 Stevens Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

David Lee Bindseil (Infant)

3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) May 15, 1948 6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day
hrs. 25 min.

9. Birthplace Abtutum, Balt. Co., Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name See A. Bindseil

13. Birthplace Baltimore City

14. Maiden name Ann. Braden

15. Birthplace Baltimore City

16. Informant See G. Bindseil, Father

Address 1331 Stevens Ave.

17. Referred to Date thereof 17 May, 1948
(month) (day) (year)

Cemetery or crematory Baltimore City Medical Examiner

Location Office for disposition

18. Funeral director Walter Braden Bradley

Address 1922 W. North Avenue

19. May 16 19 48 He. Kieffler
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15, 1948 at 1 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15, 1948 to May 15, 1948 and that I last saw him alive on May 15, 1948

Immediate cause of death

Atelactasis
Prematurity

Due to

Due to

Other conditions Premature separation of placenta 12 hours

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Earl Pass, M.D. M. D. or other

Address 4001 Wilkins Ave. Date signed 5-16-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County..... Baltimore
 City or town..... Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 11 years, seven months
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution?..... 11 years, 7 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County.....
 City or town..... Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 200 North Rose Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

HENRY
Charles Bodine Sr.

3. (b) Social Security Number

4. Sex..... male 5. Color or race..... white 6.(d) Single, married, widowed, or divorced..... married
 6.(b) Name of husband or wife..... Theresa Bodine
 7. Birth date of deceased (mo., day, yr.)..... July 17, 1876 8.(c) If alive, give age..... years
 8. AGE: Years..... 71 Months..... 10 Days..... 2 If less than one day..... hrs. min.

9. Birthplace..... Hagerstown, Maryland
 (Town, county, and state)
 10. Usual occupation..... Enameler
 11. Industry or business..... Carpentering
 12. Name..... William Bodine
 13. Birthplace..... Pennsylvania
 14. Maiden name..... Barbara Smith
 15. Birthplace..... Pennsylvania

16. Informant..... Hospital records
 Address..... Catonsville-28, Maryland
 17. Burial, cremation, or removal. Which?..... Burial Date thereof..... 3/24/48
 Cemetery or crematory..... Oak Lawn
 Location..... Baltimore, Md
 18. Funeral director..... William Bodine
 Address..... 1217 41st Ave
 19. may 24 19 48 a. w. Hedrick
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 19 19 48 at 10:50 p.m.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
October 19 19 36 to May 19 19 48
 and that I last saw him alive on May 19 19 48

Immediate cause of death..... Coronary sclerosis DURATION..... indefinite
 Due to..... Arteriosclerotic heart disease " "
 Due to..... Arteriosclerosis, generalized " "
 Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....
 Autopsy results..... none
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?.....
 23. SIGNATURE..... Isadore Tuerk, M.D. M. D. other.....
Catonsville-2, Md. Address..... Date signed..... 5-20-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

38663

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For very young infants give residence of mother)

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age years

8. AGE:

Year

Months

Days

If less than one day

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

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(Date rec'd by registrar)

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MEDICAL CERTIFICATION

20. DATE OF DEATH

May 11

19. 48 at 4:42 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5-17

19. 48 to 5-11

19. 48

and that I last saw him alive on

5-10

19. 48

Immediate cause of death

Pneumonia, Bronchial

DURATION

4 days

Due to

Gastric hemorrhage

Due to

unknown etiology

Other conditions

Sterility

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Injured at work?

Injured at work?

23. SIGNATURE

Bennett A. Roen

M. D. or other

Address

Lutherville

Date signed

5/11/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:

County... BaltimoreCity or town... Essex
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Sudden

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town... Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 603 N. Bouldin Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Herbert W. Brenner

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married8. (b) Name of husband or wife... Clara Cosgrove

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 30, 1912

8. AGE: Years Months Days If less than one day

36 1 16 hrs. min.9. Birthplace Baltimore Maryland
(Town, county, and state)10. Usual occupation... Lithographer

11. Industry or business

12. Name Gustav F. Brenner13. Birthplace Baltimore Maryland14. Maiden name Caroline Tracey15. Birthplace Baltimore16. Informant Clara BrennerAddress 603 N. Bouldin St. Balto. Md.17. Burial Date thereof 5 20 48
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Oak LawnLocation 7200 Eastern Ave. Balto. Md.18. Funeral director Lilly and Zeiler, Inc.Address 403 S. Wolfe St. Balto. 31, Md.19. May 17 1948 William M. Keely Jr.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 19 48 at 12 50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw him alive on 19.

Immediate cause of death

Coronary Occlusion - 5m

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. M. Keely Jr. M.D. or otherAddress Baltimore Date signed 5/17/48

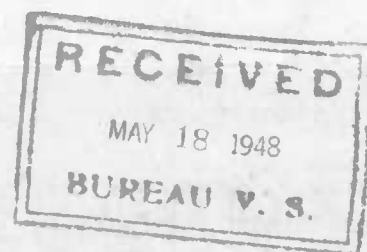
MARGIN RESERVED FOR BINDING

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VS-415 9-45-15M

VS-415

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:

County Baltimore
 City or town Pikesville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 12 years
 Hospital, institution, or street address where death occurred:
Same
 How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Balto.
 City or town Pikesville, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 16 Greiner Ave.
 (If rural, give LOCATION)
 2. (a) If veteran, name war —

3. (a) FULL NAME

JOHN MICHEL BULLINGER

3. (b) Social Security Number

212-01-0833

4. Sex

Male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Florence

7. Birth date of deceased (mo., day, yr.)

October 15, 18826. (c) If alive, give age 65 years

8. AGE:

Years

Months

Days

It less than one day

66626

hrs.

min.

9. Birthplace

Baltimore
(Town, county, and state)

10. Usual occupation

Watchman

11. Industry or business

Garrison Joint School

FATHER

12. Name

Joseph Bullinger

13. Birthplace

Baltimore, Maryland

MOTHER

14. Maiden name

Sarah H. Bullinger

15. Birthplace

Baltimore, Maryland

16. Informant

Florence O. BullingerAddress 16 Greiner Ave. Balto. 8, Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof May 14 - 48
(month) (day) (year)

Cemetery or crematory

St. Charles

Location

Pikesville, Md.

18. Funeral director

Frank H. Newell

Address

Pikesville, 8, Maryland

19.

5-12-48
(Date rec'd by registrar)19. 48Dr. E. E. Nichols
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 19 48, at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 1948 to May 11, 1948and that I last saw him alive on May 11, 1948

Immediate cause of death

DURATION

Coronary Occlusion 1/2 hr.

Due to

arteriosclerosis15 years

Due to

Hypertensive Cardiovascular disease. 20 years.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. —

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work? —

23. SIGNATURE

Louis I. Shuman
M. D. or otherAddress 1413 Reisterstown Rd. Date signed 5/12/48

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

U.S. NATIONAL BUREAU OF VITAL STATISTICS

RECEIVED
MAY 13 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 41

04666

1. PLACE OF DEATH:

County..... BALTIMORE
 City or town..... TURNERS STATION DUNDALK
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... MD County..... BALTIMORE
 City or town..... DUNDALK TURNERS STATION
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 400 LARK CT.
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3.(a) FULL NAME

MARGARET S. BUTLER

3.(b) Social Security Number

4. Sex

F

5. Color or race

C.

6.(a) Single, married, widowed, or divorced

MARRIED

6.(b) Name of husband or wife.....

John

7. Birth date of deceased (mo., day, yr.)

Nov. 27, 1896

8.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

51

hrs.

min.

9. Birthplace.....

BALTIMORE, MD
(Town, county, and state)

10. Usual occupation.....

DOMESTIC

11. Industry or business

FATHER

12. Name.....

EDWARD BEDFORD

13. Birthplace

MD

14. Maiden name.....

MATILDA COLE

15. Birthplace

MD

16. Informant.....

JOHN M. BUTLER

Address

400 LARK CT.

17.

(Burial, cremation, or removal. Which?)

Date thereof.....

6-2-48
(month) (day) (year)

Cemetery or crematory.....

ARBUTHNOT MEM. PK.

Location.....

18. Funeral director.....

Address

Joseph B. Noddy Jr.
1304 N. Central Ave

19.

6/1
(Date rec'd by registrar)

19.

48D. D. Nedrick
Dr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 5-29-48 1948, et. 3:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1948 to 5-29-48
and that I last saw her alive on 5-29-48 1948

Immediate cause of death.....

Metastatic Carcinoma -
breast

DURATION

1 yr

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address.....

423 N. W. P. B. B. B.Date signed 5-29-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH

County Baltimore
 City or town Randallstown
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

1948

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)

State Md. County Baltimore

City or town Randallstown
 (If outside city or town limits, write RURAL and give nearest town)

Street No. R. Bearstone Road
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

19 48 at 7:40 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 1st 19 48 to May 9 19 48

and that I last saw him alive on May 8 19 48

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

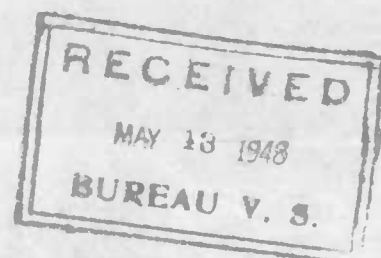
Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Randallstown Date signed 5/9/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932 pc

04668

Reg. Dist. No. 30

1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 months, 25 daysHospital, institution, or street address where death occurred:
Spring Grove State HospitalHow long in hospital or institution? 2 months, 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 3727 Milford Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

WoodsThomas/Carlile

4. Sex _____ 5. Color or race _____ 6.(a) Single, married, widowed, or divorced _____

Male White widowed6.(b) Name of husband or wife Julia August Hoff7. Birth date of deceased (mo., day, yr.) August 31, 1860

6.(c) If alive, give age _____ years

8. AGE: Years _____ Months _____ Days _____ If less than one day _____

87 8 13 _____ hrs. _____ min.9. Birthplace Harford County, Maryland
(Town, county, and state)10. Usual occupation Farmer11. Industry or business Farm12. Name William Carlile13. Birthplace England14. Maiden name Susan Peters15. Birthplace Sweden16. Informant Hospital recordsAddress Catonsville 28, Md.17. Burial Date thereof 5/17/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Druid Ridge Cem.
Pikesville, Md.

Location _____

18. Funeral director WM. J. TICKNER & SONSAddress Baltimore 17, Md.19. 5/17 48 A. V. Hedrick
(Date rec'd by registrar) (month) (day) (year) Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 19 48 at 8:00 p.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
February 19 19 48 to May 13 19 48and that I last saw him alive on May 13 19 48

Immediate cause of death _____

Coronary thrombosis DURATION approx.Right lung congestion 1 hourArteriosclerotic cardiovascular severaldisease hoursOther conditions _____ indefinite

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Isadore Tuerk, M.D. M. D. or otherAddress Catonsville 28, Md. Date signed 5/14/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County BaltimoreCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD CountyCity or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)Street No. 201 Solles Point Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Shirley Ann Cheatham

3. (b) Social Security Number

4. Sex Female5. Color or race Colored6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Oct. 1, 1928

6. (c) If alive, give age..... years

8. AGE: Years 19 Months Days If less than one day
..... hrs. min.9. Birthplace MD
(Town, county, and state)10. Usual occupation Waitress

11. Industry or business

12. Name Glover Cheatham13. Birthplace MD14. Maiden name Dorothy Wheeler15. Birthplace MD16. Informant Glover CheathamAddress 201 Solles Point Road17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof May 6, 1949
(month) (day) (year)Cemetery or crematory Mt Calvary CemeteryLocation A. A. County18. Funeral director Miss Lott E. Elliott & DaughertyAddress 1129 N. Caroline St.19. May 6, 1948 Registrar Q. N. Hedrick
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3, 1948, at 3:28 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1, 1948, to May 3, 1948and that I last saw him alive on May 3, 1948Immediate cause of death Pneumonia

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Gullin S. Hade, M.D. M. D. or otherAddress 140 Oak Ave Date signed 5-3-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131a

04670

Reg. Dist. No. 37

1. PLACE OF DEATH:

County Balto
City or town Tinsomon, Ind.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Ind. County Balto.
City or town Tinsomon
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Lucie B. Cherbonnier.

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed.

6.(b) Name of husband or wife Caleb Cherbonnier.
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) (Unknown) 1858

8. AGE: Years abt. 90 Months Days less than one day hrs. min.

9. Birthplace St. Louis Mo.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name C. H. Boisjournere

13. Birthplace St. Paul

14. Maiden name Mrs. White

15. Birthplace Kentucky

16. Informant Catherine Evers

Address Tinsomon, Ind.

17. Burial Burial Date thereof May 12, 1948
(Burial, cremation, for removal, which) (month) (day) (year)

Cemetery or crematory St. Joseph's Cemetery

Location Tinsomon, Ind.

18. Funeral director John Burns Sons

Address Tinsomon, Ind.

19. 5/10-48 Wilmer C. Ensor
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-19 1948 at 1:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 15 1946 to 5/9 1948
and that I last saw her alive on 5/9 1948

Immediate cause of death Uremic Coma DURATION 2 days

Due to Nephritis

Due to Senility

Other conditions Arterio sclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wilmer C. Ensor M.D. M. D. or other

Address Cochyville Ind. Date signed 5/10/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

RECEIVED
MAY 14 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Ingleside Convalescent Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HowardCity or town Ellicott City
(If outside city or town limits, write RURAL and give nearest town)Street No. Edmonson Ave Extended
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Louise P Claggett

3. (b) Social Security Number

none

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

Eli Claggett

6.(c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

Jan 13, 1862

8. AGE:

Years

Months

Days

If less than one day

86319

hrs.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

none

11. Industry or business

MOTHER FATHER

12. Name

Alvin J P. Tabler

13. Birthplace

WVa

14. Maiden name

Anna L. Hughes

15. Birthplace

Md.

16. Informant

Mrs. Rebecca Hayes

Address

Ellicott City Md.

17.

Burial
(Burial, cremation, or removal. Which?)

Date thereof

5-5-48
(month) (day) (year)

Cemetery or crematory

Landon Park

Location

Baltimore Md.

18. Funeral director

J.C. Dig. undertaker

Address

Ellicott City Md.

19.

May 5 1948
(Date received by registrar)W.E. Harry

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 319 48

at

3 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 2419 47

to

May 319 48

and that I last saw him alive on

May 219 48

Immediate cause of death

Arteriosclerosis Cordis-renal
disease

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John B. Kochman MD

M. D. or other

Address

Ellicott City Md

Date signed

5/31/48

RECEIVED

MAY 6 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 3/

1. PLACE OF DEATH:
County Baltimore
City or town Owings Mills
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 weeks
Hospital, institution, or street address where death occurred:
Dolfield Road Owings Mills Md
How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Owings Mills
(If outside city or town limits, write RURAL and give nearest town)
Street No. / Dolfield Road
(If rural, give LOCATION)
2. (a) If veteran, name war -

3. (a) FULL NAME Betty Joyce Clarkson
3. (b) Social Security Number None

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced S

6. (b) Name of husband or wife -

7. Birth date of deceased (mo., day, yr.) July 24 1947 6. (c) If alive, give age - years

8. AGE: Years - Months 9 Days 16 If less than one day - hrs. - min.

9. Birthplace Holbrook Balto Co Md
(Town, county, and state)

10. Usual occupation -

11. Industry or business -

FATHER 12. Name Charles Edwin Clarkson

13. Birthplace Indiana

MOTHER 14. Maiden name Eunice Estes

15. Birthplace Rockhold Ky

16. Informant Mrs Eunice Clarkson

Address Owings Mills

17. Burial Burial Date thereof May 13 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Elliott Cemetery

Location Rockhold Ky

18. Funeral director Wm Berryman & Sons

Address Reisterstown Md

19. 7/11/48 1948 Wm E. J. Martin
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10, 1948 21 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 24, 1947 to May 10, 1948
and that I last saw him alive on May 9, 1948

Immediate cause of death Cerebral
collapse & cerebral aneurysm
following rupture of
hypertensive aneurysm, and
loss of large quantity of
spinal fluid
Other conditions hydrocephalus +
spinal fluid
(Include pregnancy within 3 months of death)

Major findings of operations -

Date of op. -

Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -

Where did injury occur? - (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -

Means of injury - Injured at work? -

23. SIGNATURE Wm E. J. Martin M. D. or other

Address Pandallstown Date signed 7/11/48

MARGIN RESERVED FOR BINDING

VS A15 1945.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 13 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

04672

38

1. PLACE OF DEATH:

County Baltimore

City or town Towson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years 16 days

Hospital, institution, or street address where death occurred:

Sheppard & Enoch Pratt Hospital

How long in hospital or institution? 4 years 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Alabama County

City or town Birmingham

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1504 - 15th Avenue, S.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

(Mrs.) Ida Greenwald Cohen

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

Jacob Cohen

7. Birth date of deceased (mo., day, yr.)

about March 15, 1885(?)

6. (c) If alive, give age years

8. AGE:

Years (?) 63

Months

2

Days

13

If less than one day

hrs. min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Lieb Greenwald

12. Name

Russia

13. Birthplace

unknown

14. Maiden name

Russia

15. Birthplace

16. Informant

Hospital records

Address

Sheppard-Pratt Hosp, Towson, Md
Demmed Date thereof 5-28-48

17. (Burial, cremation, or removal, which?)

Cemetery or crematory

Birmingham, Ala

Location

18. Funeral director

Jack Leure Inc

Address

2100 Eastview Place

19.

(Date rec'd by registrar)

19

5/29

x 8

Dr. H. H. H. H.

Dr

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 19 48 at 6:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 13 19 46 to May 28 19 48

and that I last saw her alive on May 28 19 48

Immediate cause of death

Lobar pneumonia

DURATION

7 days

Due to

Arteriosclerotic cardiovascular disease

Due to

Senile psychosis

Other conditions

Diabetes mellitus

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Harry H. H. H.

M. D. or other

Address Sheppard-Pratt, Towson, Md

Date signed 5-28-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Form No. G 116 JUL 6 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 04623 38

1. PLACE OF DEATH:

County **BALTIMORE**
City or town **TOWSON, 4**
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? **28 Years**
Hospital, institution, or street address where death occurred:
100 Burke Avenue
How long in hospital or institution? **—**

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State **Maryland** County **Baltimore**
City or town **Towson, 4**
(If outside city or town limits, write RURAL and give nearest town)
Street No. **100 Burke Avenue**
(If rural, give LOCATION)
2.(a) If veteran, name war **—**

3. (a) FULL NAME

EFFIE LAVINIA COOPER

3. (b) Social Security Number

4. Sex **Female** 5. Color or race **White** 6.(a) Single, married, widowed, or divorced **Married**
6.(b) Name of husband or wife **Clarence G. Cooper**
6.(c) If alive, give age **64** years
7. Birth date of deceased (mo., day, yr.) **June 14, 1886**
8. AGE: Years **61** Months **10** Days **19** If less than one day **—** hrs. **—** min.
9. Birthplace **Parkton, Balto. Co., Maryland**
(Town, county, and state)
10. Usual occupation **Housewife**
Own home
11. Industry or business

FATHER 12. Name **George W. Hare**
13. Birthplace **Maryland**
MOTHER 14. Maiden name **Elizabeth Palmer**
15. Birthplace **Maryland**
16. Informant **Clarence G. Cooper**
Address **100 Burke Avenue, Towson, 4, Md.**
17. **Burial** Date thereof **May 5, 1948**
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory **Parkwood Cemetery**
Location **Parkville, Md.**
18. Funeral director **John Burnie, Sons**
Address **Towson, Maryland**
19. **May 5, 1948** **2 P.M. Bacon**
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **May 3** 19 **48** at **7:05 P.M.**
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **Jan. 1, 1945** 19 **48** to **May 3** 19 **48**
and that I last saw **or** alive on **May 3** 19 **48**
Immediate cause of death
Cardiac failure
Respiratory failure
Due to **Carcinomatosis** DURATION **12 hrs.**
Due to **Symptoms & mass suggest**
Care of large bowel
Other conditions **Arthritis (atrophic)** **15 years**
Pernicious Anemia **12 years**
(Include pregnancy within 3 months of death)
Major findings of operations **None**
Date of op. **—**
Autopsy results **None**
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide **—** Date of **—**
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury **—** Injured at work?
23. SIGNATURE **Donald D. Cooper** M. D. or other
Address **100 Burke Ave., Towson, 4** Date signed **May 3, 1948**

MARGIN RESERVED FOR BINDING

VS A15 9-45-5M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 8 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County BaltimoreCity or town Franklinville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mary Elizabeth Cornes

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Lawrence W. Cornes

7. Birth date of deceased (mo., day, yr.)

May, 25, 1897

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

501121

hrs.

min.

8. Birthplace

Bradshaw, Maryland
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

George Dollinger

13. Birthplace

Maryland

14. Maiden name

Brabara Bellymer

15. Birthplace

Maryland

16. Informant

Lawrence W. Cornes

Address

Franklinville Md.

17.

Burial

Date thereof

May, 19, 1948
(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Jerusalem Christian

Location

Joppa Md.

18. Funeral director

Howard K. McComas & Son

Address

Abingdon Md.

19.

May 19 1948

(Date read by registrar)

G. E. ArthurDeath Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Franklinville
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 19 48 at 8:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 26 19 46 to May 16 19 48and that I last saw him alive on May 16 19 48

Immediate cause of death

Coronary occlusion DURATION 15 MIN.Due to Toxic Myocarditis 3 MOS.with Atrial FibrillationDue to Graves Disease 1 yr.

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury

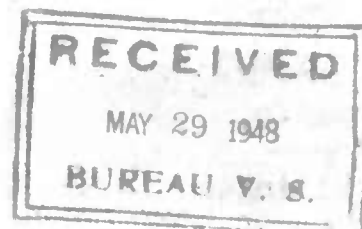
Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed 5/19/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH: Baltimore
 County.....
 City or town.....Johnnycake Rd.
 (If outside city or town limits, write RURAL and give nearest town)
 How long above place of death?.....2 days
 Hospital, institution, or street address where death occurred.....
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....Md. County.....Howard
 City or town.....Sykesville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....R.F.D.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....None

3. (a) FULL NAME.....Elsie May Cornwell
 3. (b) Social Security Number.....218-14-8499

4. Sex.....Female 5. Color or race.....White 6.(a) Single, married, widowed, or divorced.....Married
 8.(b) Name of husband or wife.....Elmer F. Cornwell
 7. Birth date of deceased (mo., day, yr.).....July 16 1907
 8. AGE: Years.....40 Months.....9 Days.....29 If less than one day..... hrs. min.

9. Birthplace.....Virginia
 (Town, county, and state)
 10. Usual occupation.....Spinner in Cotton Mill

11. Industry or business.....
 12. Name.....James Lee
 13. Birthplace.....Manassas, Va.
 14. Maiden name.....Gertrude Pearson
 15. Birthplace.....Manassas, Va.

18. Informant.....Mr. Elmer Cornwell
 Address.....Johnnycake Rd. E.C.F.D.
 17. Burial Date thereof.....May 17 1948
 (Burial, cremation, or removal, which?) (month) (day) (year)
 Cemetery or crematory.....Good Shepherd
 Location.....Rogers Ave. Ellicott City

18. Funeral director.....Easton Sons
 Address.....Ellicott City, Md.
 19. May 16 1948 VE. Harry
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....May 14, 1948, at 9:45 AM
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 13 1948 to May 14 1948
 and that I last saw her alive on May 14 1948

Immediate cause of death.....Generalized metastases
 Due to.....Carcinoma of ovary
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of
 Where did injury occur?.....
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury..... Injured at work?.....

23. SIGNATURE.....Edwin J. ...
 M. D. or other
 Address.....Ellicott City, Md.
 Date signed.....5/15/48

RECEIVED

MAY 18 1948

BUREAU V. 8.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 428 days

Hospital, institution, or street address where death occurred:

Veterans Administration HospitalHow long in hospital or institution? 428 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 1104 McDonald Street
(If rural, give LOCATION)2.(a) If veteran, name war WWII

3. (a) FULL NAME

ALTON COVINGTON

3. (b) Social Security Number

Unknown

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 17, 1925

8. AGE: Years Months Days If less than one day

22912

hrs. min.

9. Birthplace Little Rock, S.C.
(Town, county, and state)10. Usual occupation Unemployed

11. Industry or business

12. Name Unknown13. Birthplace "14. Maiden name Unknown15. Birthplace "16. Informant Clinical Records, Vet. Adm. Hosp.Address Fort Howard, Md.17. Burial Date thereof June 3, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Holly CemeteryLocation Little Rock, S.C. Dillon County18. Funeral director Joseph H. AdamsAddress 661 W. Barre St. Balto. Md.19. 6/1 48 H. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 19 48 at 9:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 28, 1947 19 48 to May 29 19 48and that I last saw him alive on May 29 19 48

Immediate cause of death

WIDESPREAD CASEOUS TUBERCULOSIS DURATION UnknownOther conditions: Pneumothorax,not partial, spontaneous, left, sec-ondary to Tuberculosisxxx Boeck's sarcoid UnknownUveitis, bilateral, chronic, due tounknown Boeck's sarcoid UnknownCataract, mature, right eye Unknown

(Include pregnancy within 9 months of death)

Major findings of operations

Date of op.

Autopsy results Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul PadgetPAUL PADGET, M.D., CHIEF, MED. SERVICEAddress VAH, Fort Howard, Md. Date signed 6/1/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:

County Baltimore

City or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

2650 Yorkway

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Baltimore

City or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2650 Yorkway
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Olive E. Cox

3. (b) Social Security Number

4. Sex

F.

5. Color or race

W.

6.(a) Single, married, widowed, or divorced

m.

6.(b) Name of husband or wife

Chester C. Cox

7. Birth date of deceased (mo., day, yr.)

May 23, 1893

8.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

55

0

1

hrs.

min.

9. Birthplace

Greenwood, Delaware
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

John H. Willey

13. Birthplace

Delaware

MOTHER

14. Maiden name

Sarah Richards

15. Birthplace

Delaware

16. Informant

Chester C. Cox

Address

2650 Yorkway, Dundalk, Md.

17.

(Burial, cremation, or removal, Which?)

Date thereof

May 26, 1948
(month) (day) (year)

Cemetery or crematory

Bridgetown

Location

Bridgetown, Delaware

18. Funeral director

Roland L. Fisher

Address

2112 Dundalk Ave.

19.

May 24, 1948
(Date rec'd by registrar)

W. Freely, Jr.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24, 1948, at 19.48 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 47, 1947 to 24 May 1948

and that I last saw him 23 May 1948 alive on

Immediate cause of death

Carcinoma of breast with metastases to liver, lungs, ribs.

DURATION

10 years.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

metastases to liver

Date of op.

29 April 1948

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Bernard W. Jacob M.D.

M. D. or other

Address

8 Liberty Parkway

Date signed

24 May 48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

04678

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore
 City or town 108 Shadybrook Ave. Catonsville
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balts.City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)Street No. 108 Shadybrook Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Alice C. Davis

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Albert B. Davis

7. Birth date of

deceased (mo., day, yr.)

Nov. 13, 1863

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

It less than one day

84526

hrs.

min.

9. Birthplace

West Va.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

Luke Conley

13. Birthplace

West Va.

MOTHER

14. Maiden name

Margaret McWhorter

15. Birthplace

West Va.

16. Informant

Harper T. Davis

Address

108 Shadybrook Ave.

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Burial
Landon Park

Location

Baltimore

18. Funeral director

George A. Farley

Address

Orebank & Shadybrook Aves.

19.

(Date rec'd by registrar)

5-12 1948V.E. Harry

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 91948at 10:00 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Feb1931to May 91948

and that I last saw him alive on

May 81948

Immediate cause of death

Coronary Occlusion

DURATION

Sudden

Due to

Coronary Occlusion
C. Hypertension10 Year

Due to

Other conditions

Cholecystitis and
Cholelithiasis
(Include pregnancy within 3 months of death)3 Year

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

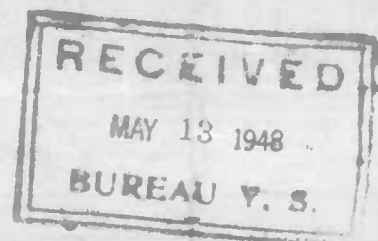
23. SIGNATURE

Eliot W. Johnson

M. D. or other

Address

3432 Indiv. Ave.Date signed 5/19/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The carriage is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? since March 17, 1948Hospital, institution, or street address where death occurred:
Spring Grove State HospitalHow long in hospital or institution? since March 17, 1948

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CharlesCity or town Cobb Island
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Ella Frances DEANE

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FWmarried6. (b) Name of husband or wife George A. Dean7. Birth date of deceased (mo., day, yr.) 12/7/18858. AGE: Years Months Days If less than one day
62 4 29 hrs. min.9. Birthplace Maryland
(Town, county, and state)10. Usual occupation housewife11. Industry or business home12. Name John D. Clarke13. Birthplace ?14. Maiden name Carrie Bell15. Birthplace ?16. Informant Hospital recordsAddress Catonsville-28, Maryland17. Burial Date thereof May 8, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Cedar Hill Cem.Location Washington, D.C.18. Funeral director W. W. Chambers & Co.Address Washington, D.C.19. May 7 19 48 V.E. Hays
(Date recd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6th, 1948 19 _____ at 12, 05 Pm21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
March 17, 1948 19 _____ to May 6th 19 48
and that I last saw her alive on May 6th, 1948 19 _____Immediate cause of death
Right lower lobar pneumonia 2 days
Coronary sclerosis indef.Due to Generalized atheromatosis indef.

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Abraham M. Schneidmuhl, M.D.
M. D. or otherAddress Catonsville-28, Md. Date signed 5/6/48

RECEIVED

MAY 8 1948

BUREAU Y. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04680
41

1. PLACE OF DEATH:

County 402 Arundale Rd Turner StationCity or town Baltimore Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Hayes De Graffon Reed

4. Sex

M

5. Color of race

W

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Ann Carrie De Graffon Reed

7. Birth date of

deceased (mo., day, yr.)

1/15 - 1888

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

60314hrs.min.

9. Birthplace

(Town, county, and state)

Ala.

10. Usual occupation

Coal Dealer

11. Industry or business

FATHER

12. Name

Samuel De Graffon Reed

13. Birthplace

Ala

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Annie De Graffon Reed

Address

402 Arundale Rd Turner Station

17.

(Burial, cremation, or removal. Which?)

Date thereof

Burial
May 13, 1948
(month) (day) (year)

Cemetery or crematory

Mt Auburn

Location

Baltimore Md

18. Funeral director

Wm A Jackson

Address

916 Penna Ave

19.

(Date rec'd by registrar)

19.

48

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 9,1948at 3:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 9,1948to May 9,1948

and that I last saw him alive on

May 9,1948Immediate cause of death Cornary Thrombosis

DURATION

✓

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

William E. Hodge, M.D.

M. D. or other

Address

140 Oak AveDate signed 5-9-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH *BC*

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04681 *44*
Reg. Dist. No.

1. PLACE OF DEATH:

Cenely Baltimore
City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 126 Days
Hospital, institution, or street address where death occurred:
Vets. Adm. Hospital, Ft. Howard, Maryland
How long to hospital or institution? 126 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County _____
City or town 13 Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 13 S. Chester Street
(If rural, give LOCATION)
2.(a) If veteran, name war WW-I

3. (a) FULL NAME

RAYMOND DIX

3. (b) Social Security Number

215-16-6056

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widower
6. (b) Name of husband or wife Widower
7. Birth date of deceased (mo., day, yr.) 6-6-1890 8. (c) If alive, give age _____ years
8. AGE: Year 57 Month 10 Days 8 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)10. Usual occupation Watchman

11. Industry or business _____

12. Name George Dix13. Birthplace Unknown14. Maternal name Betty Kelley15. Birthplace Virginia

16. Informant Clinical Records, Vets. Adm. Hospital
Address Fort Howard, Maryland

17. Burial Date thereof MAY 18 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Holy RedeemerLocation 4300 BELAIR RD.18. Funeral director Dippel Bros.Address 37 S. Ann St. Balto., Md.

5/17 19 48 A.W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14, 19 48 1:14 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
January 9, 19 48, to May 14, 19 48
and that I last saw him alive on May 14, 19 48

Immediate cause of death SHOCK AND HEMORRHAGE
FOLLOWING AMPUTATION OF LEG.

Diabetic Coma
Due to Diabetes Mellitus and
Diabetic Gangrene

Other conditions Diabetes Mellitus
Post-operative shock
(Include pregnancy within 3 months of death)

Major findings of operations _____
Date of op. _____

Autopsy results Substantiated above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Richard Land M.D. M. D. or other _____

Address Fort Howard, Md. Date signed 5/14/48

DURATION
4 Days
5 Days
Unk.
6 days
Unknown

Additional information for cause of death added from a corrected copy of the death certificate sent in by the Registrar at the Veterans Hosp.

5-27-48 - ams

W 1876

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

04682

83a

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 26 Jones Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Amoss H. Dorsey

3. (b) Social Security Number

None

4. Sex M 5. Color or race C 6.(a) Single, married, widowed, or divorced Widower

6.(b) Name of husband or wife Hanna Mary Dorsey

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 13, 1861

8. AGE: Years 87 Months 2 Days 24 If less than one day
.....hrs.min.

9. Birthplace Howard County, Md.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

12. Name Unknown

13. Birthplace It

14. Maiden name It

15. Birthplace It

16. Informant Louis Kelly

Address Simpsonville, Md

17. Burial Date thereof 5-10-48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Locust Chapel

Location Atholton, Md.

18. Funeral director F.C. Higinbotham

Address Ellicott City, Md

19. 5-10 19 48 W.E. Harvey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 19 48 at 12:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 2nd 19 48 to May 7th 19 48
and that I last saw him alive on May 7th 19 48

Immediate cause of death

Cerebral Hemorrhage DURATION 6 days

Due to Gen. Arterio-sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Ch. J. Maloney M.D. M. D. or other

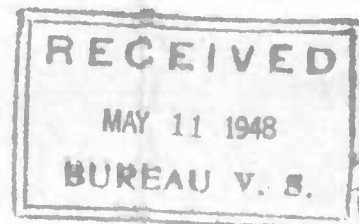
Address Catonsville Md Date signed 5-7-48

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In correction is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County BALTIMORECity or town HALETHORPE
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

1318 ELM. RD.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BALTIMORECity or town HALETHORPE
(If outside city or town limits, write RURAL and give nearest town)Street No. 1318 ELM RD
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

LAURA E. DURNER

3. (b) Social Security Number

4. Sex

FEMALE

5. Color or race

WHITE

6.(a) Single, married, widowed, or divorced

WIDOWED6.(b) Name of husband or wife JAMES B. DURNER

8.(c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

MARCH. 28, 1869

8. AGE:

Years

Months

Days

If less than one day

7919

hrs.

min.

9. Birthplace

MARYLAND

(Town, county, and state)

10. Usual occupation

HOUSE WIFE

11. Industry or business

OWN HOME

FATHER

12. Name

JOSEPH D. MYERS

13. Birthplace

MARYLAND

MOTHER

14. Maiden name

ADELING GRIFFITH

15. Birthplace

MARYLAND

16. Informant

LAURENCE TADGE

Address

1318 ELM AVE

17.

(Burial, cremation, or removal. Which?)

Date thereof

May 10, 1948
(month) (day) (year)

Cemetery or crematory

Norwood Memorial Pk.

Location

Washington Blvd

18. Funeral director

Joseph J. Ambrose, Jr.

Address

4414 N. Frankforton St.

19.

(Date rec'd by registrar)

May 10, 1948Dr. J. J. Ambrose, Jr.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 1948, at 9 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 6 1947, to May 6 1948
and that I last saw h. x alive on May 6 1948

Immediate cause of death

Myocardial infarction & arteriosclerosis
Cardiac vessels blocked
Myocardium

DURATION

2

Due to

Due to

Other conditions

Coronary artery disease
right breast
(Include pregnancy within 3 months of death)7 mos.

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Albert J. Ambrose, Jr.

M. D. or other

Address 2302 Edmonson Rd. Date signed 5/6/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:

County... BaltimoreCity or town... Relay, 27, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? April 23, 1948

Hospital, institution, or street address where death occurred:

Relay Sanitarium

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Baltimore CityCity or town...
(If outside city or town limits, write RURAL and give nearest town)Street No. 3511 Coolidge Ave; Baltimore 29, Md.

(If rural, give LOCATION)

2.(a) If veteran, name war.....✓

3.(a) FULL NAME

Edelmann, Florence H. Mrs.

3.(b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed6.(b) Name of husband or wife... deceased Charles H.7. Birth date of deceased (mo., day, yr.) Feb. 22, 18738. AGE: Years Months 2 Days If less than one day
** 75 ** Feb. 12hrs.min.9. Birthplace... Baltimore, Md.
(Town, county, and state)10. Usual occupation... Housewife

11. Industry or business

12. Name... Benjamin Franklin Emery13. Birthplace... Baltimore, Md.14. Maiden name... Anne Marie Taylor15. Birthplace... Baltimore, Md.16. Informant... Louis D. EdelmannAddress... 5008 Edmondson Ave; Balto. 29, Md.17. Burial Date thereof... May 7, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... Loudon Park CemeteryLocation... Baltimore Maryland18. Funeral director... F.B.WIPPERT & SONAddress... 1300 EUTAW PLACE... 1719. may 6 48 a.w. Hedges
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... May 4 19 48, at 12:30 Noon21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
April 23, 1948 19... to 5-4-48 19...and that I last saw her... alive on 5-4-48 19...

Immediate cause of death...

Cerebral hemorrhageDue to... hypertension but since

Due to...

Other conditions... Left pulmonary

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op.

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Emory P. Gandy M.D.Address... Relay, 27, Md. Date signed 5-4-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1572 04650 40

1. PLACE OF DEATH:

County... Baltimore

City or town... Whitemarsh, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?... life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?...

3. (a) FULL NAME

Baby Boy Eurice

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

May 29th, 1948

8. AGE:

Years

Months

Days

if less than one day

9

hrs.

30

min.

9. Birthplace

Baltimore County, Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

William G. Eurice

13. Birthplace

Baltimore, Md.

MOTHER

14. Maiden name

Amy A. Skinner

15. Birthplace

Pa.

16. Informant

Mr. William G. Eurice

Address

Old Philadelphia, Whitemarsh, Md.

17. burial

(Burial, cremation, or removal. Which?)

Date thereof

5/30/48

(month) (day) (year)

Cemetery or crematory

Camp Chapel Methodist

Location

Raspeburg, Md.

18. Funeral director

Lassahn Funeral Home

Address

7401 Belair Rd.

19.

(Date rec'd by registrar)

1948

5/29

1948

5/29

1948

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5/29

1948

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Baltimore

City or town

Whitemarsh, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Old Philadelphia Rd.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 29

1948

at

5:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 29

1948

to

May 29

1948

and that I last saw him alive on

May 29

1948

Immediate cause of death

Patent foramen

ovale

DURATION

Due to

Prematurity

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Balto 6

Date signed 5-29-48

RECEIVED

JUN 7 1948

BUREAU V. 8.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County... BaltimoreCity or town... Arbutus
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 27 yrs

Hospital, institution, or street address where death occurred:

7506 Selma ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... md County... BaltimoreCity or town... Arbutus
(If outside city or town limits, write RURAL and give nearest town)Street No... 5506 Selma ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Elizabeth Leager Fallon

3. (b) Social Security Number

none

4. Sex

Female

5. Color of race

white

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

John Fallon

7. Birth date of deceased (mo., day, yr.)

Nov. 19 1964

8. AGE:

Years 83 Months 6 Days 6 If less than one day

hrs. min.

9. Birthplace

Kent County md
(Town, county, and state)

10. Usual occupation

Homemaker

11. Industry or business

12. Name

Edburn

13. Birthplace

Kent County md

14. Maiden name

Eliza Leager

15. Birthplace

Kent Co. md

16. Informant

Mrs. Leager Leager

Address

5506 Selma ave Arbutus

17. (Burial, cremation, or removal, Which?)

Burial

Cemetery or crematory

London Park

Location

Arbutus md

18. Funeral director

William J. Day

Address

1214 LP Paul19. May 27 48 A.W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1948 at 10 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 4 1948 to May 25 1948and that I last saw him alive on May 25 1948

Immediate cause of death

Carcinoma ofCervixDue to Extensive carcinomain situDue to Prostatic carcinomaterminalOther conditions Myocardialinfarction

(Include pregnancy within 9 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Edmund Hedrick

Address

Elbridge mdDate signed 3/27/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04686

Reg. Dist. No. 44

1. PLACE OF DEATH

County Baltimore County
City or town Sparrows Pt
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md County Baltimore
City or town Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)
Street No. 206 D St
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

BEVERLY JENE FISHER

3. (b) Social Security Number

NONE

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

SINGLE

6. (b) Name of husband or wife

Dec

6. (c) If alive, give age 48

7. Birth date of

deceased (mo., day, yr.)

Dec 25 - 1948

8. AGE:

Years

Months

Days

If less than one day

1 yr

4

29

hrs. min.

9. Birthplace

Baltimore County Md

(Town, county, and state)

10. Usual occupation

NONE

11. Industry or business

FATHER

12. Name

GUY E. FISHER

13. Birthplace

PA

MOTHER

14. Maiden name

MARY F. MARSHALL

15. Birthplace

PA

16. Informant

MR GUY E FISHER

Address

206 D ST. SP. PT.

17. (Burial, cremation, or removal, which?)

Burial

Date thereof

May 26 - 1948

Cemetery or crematory

Caplaw

Location

Baltimore Md

18. Funeral director

H. Smith & Son

Address

1649 E. North Ave

19. (Date rec'd by registrar)

May 25 - 48

Dawson J. Fisher

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 25 1948 at 5:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 1948 to May 25 1948
and that I last saw him alive on May 25 1948

Immediate cause of death

Cardio-respiratory failure

DURATION

2 days

Due to

chronic

1 month

Due to

Post influenza meningitis

3 months

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Robert E. Fisher

M.D.

Address Sparrows Point, Md Date signed 5/25/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 3 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04687

Reg. Dist. No. 35

1. PLACE OF DEATH: Balto. Co.
 County..... Mercy Villa
 City or town..... Bellona Avenue
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 7 Years
 Hospital, institution, or street address where death occurred:
Bellona Avenue
 How long in hospital or institution?..... 7 Years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County.....
 City or town..... Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 2811 Guilford Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Katherine Fitzgerald

3. (b) Social Security Number

4. Sex..... Female
 5. Color or race..... White
 6.(a) Single, married, widowed, or divorced..... Single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)..... February 5, 1854
 8. AGE: Years..... 94 Months..... 3 Days..... 12
 If less than one day..... hrs. min.

9. Birthplace..... Texas, Baltimore Co., Md.
 (Town, county, and state)

10. Usual occupation..... None

11. Industry or business.....

FATHER 12. Name..... Edward Fitzgerald13. Birthplace..... IrelandMOTHER 14. Maiden name..... Johanna Buckley15. Birthplace..... Ireland16. Informant..... Matthias C. SheaAddress..... 2811 Guilford Avenue

17. Baltimore Date thereof..... 5/20/48
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory..... St. Joseph's.Location..... Texas, Md.18. Funeral director..... W. W. Meeks and SonAddress..... 805 N. Calvert Street

19. 5/19 19. 5/19
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 5-16 19. 48, at 1 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1-4 19. 48, to 5-16 19. 48and that I last saw her..... alive on 5-16 19. 48

Immediate cause of death.....

Arteriosclerotic Cardio-Vascular Disease

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

M. D. or other

Address.....

Date signed..... 5-19-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04688

94a

Reg. Dist. No. 30

1. PLACE OF DEATH:

County BaltimoreCity or town Baltimore 29
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Baltimore 29
(If outside city or town limits, write RURAL and give nearest town)Street No. 4146 Wilkins Ave
(If rural, give LOCATION)

2.(d) If veteran, name war

3. (a) FULL NAME

James Richard Floyd

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

M

W

Married

6. (b) Name of husband or wife Mary Jane Floyd

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9, 18888. AGE: Years Months Days If less than one day
60 0 13 hrs. min.9. Birthplace Lynchburg Va
(Town, county, and state)10. Usual occupation Machinist

11. Industry or business

12. Name Nathan C. Floyd13. Birthplace Va14. Maiden name Mary J. Ford15. Birthplace Va16. Informant Mrs. M. J. FloydAddress 4146 Wilkins Ave. Baltimore 29, Md17. Burial Date thereof 5-26-48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Loudon ParkLocation Baltimore, Md.18. Funeral director F. C. HiginbothamAddress Ellicott City, Md.19. 5/25 1948 V.E. Harry
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1948 at 10 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19.38 to May 22 1948and that I last saw him alive on about May 7th 1948Immediate cause of death Cornary Th. Arteriosclerosis

DURATION

14 minutesDue to Cornary Sclerosis - previousattack with hospitalizationDue to 2 yrs ago

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Fredrick A. Beiter

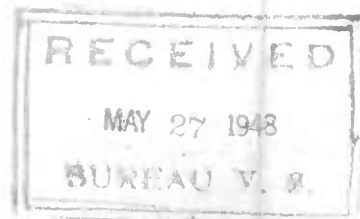
M. D. or other

Address 723 Med. Co. & Th. Bldg. - Balt. Date signed May 25-48

Dr. Beitler

1014 Francis Ave

Arbutus 664



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH: Baltimore
County Granite Md.
City or town Granite Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 mo.
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Joseph Flynn

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Separated

6. (b) Name of husband or wife Frank
6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) (?) 1876

8. AGE: Years 72 Months ? Days ? If less than one day _____ hrs. _____ min.

9. Birthplace Schenectady N.Y.
(Town, county, and state)

10. Usual occupation Broom maker

11. Industry or business

12. Name Patrick Flynn

13. Birthplace Ireland

14. Maiden name Catherine Mulvey

15. Birthplace Ireland

16. Informant Miss Clara Flynn

Address Summit Ave. Woodstock

17. Burial Date thereof May 10, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Alphonsus Cem.

Location Woodstock, Md.

18. Funeral director E. Astor Sons

Address Callicott City Md.

19. 5/6/48 1948 Tom E. Martin
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Woodstock P.O.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Summit Ave. Granite Md.
(If rural, give LOCATION)

2. (a) If veteran, name war

None

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6, 1948, at 9 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 1st 1948 to May 6 1948
and that I last saw him alive on May 5 1948

Immediate cause of death Cerebral hemorrhage DURATION 1 hr

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Antepartum results _____

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

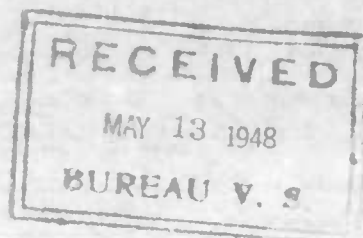
23. SIGNATURE Tom E. Martin M. D. or other _____

Address Woodstock Date signed 5/6/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04690 33

1. PLACE OF DEATH:

County... Baltimore
 City or town... Owings Mills, Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 18 yrs 7 mo 15 days
 Hospital, institution, or street address where death occurred:
Rosewood State Training School
 How long in hospital or institution? 18 yrs 7 mo 15 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Md County...
 City or town... Baltimore City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1038 N. Brentwood Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Margaret Ann Franz

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

January 11, 1924

6. (c) If alive, give age..... years

8. AGE:

24

Years

4

Months

Days

18

If less than one day

hrs. min.

9. Birthplace

Baltimore, Md.
(Town, county, and state)

10. Usual occupation

Inmate; Rosewood State Training School; Owings Mills, Md

11. Industry or business

MOTHER FATHER

12. Name

Lawrence J. Franz

13. Birthplace

Baltimore, Md.

14. Maiden name

Margaret A. Kelly

15. Birthplace

Baltimore, Md.

16. Informant

Institutional Record; Rosewood

Address

State Training School; Owings Mills

17.

Burial
(Burial, cremation, or removal, Where?)

Date thereof

6/1/48
(month) (day) (year)

Cemetery or crematory

Holy Redeemer

Location

Bethel Rd Baltimore

18. Funeral director

Joseph J. Ruak

Address

5305 Harford Rd.

19.

6/1
(Date rec'd by registrar)

19.

48Ab. HedrickDM Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 29 1948 at 5:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 26 1948 to May 29 1948and that I last saw her alive on May 29 1948

Immediate cause of death

Bronchopneumonia

DURATION

2 days

Due to

Bronchitis5 days

Due to

Congenital organicLifeNeurological Imbecile

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

noneDate of op. none

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE

George C. Medairy M.D.Address... Owings Mills, Md Date signed... 5/29/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No.

04691

43

1. PLACE OF DEATH:

County..... Baltimore
 City or town..... Raspeburg, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... life
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland..... County..... Baltimore
 City or town..... Raspeburg, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 6200 Hamilton Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Carrie Eva Freund
 4. Sex..... female
 5. Color or race..... white
 6. (a) Single, married, widowed, or divorced..... single

3. (b) Social Security Number

6. (b) Name of husband or wife

6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... March 13th, 1884

8. AGE: Years..... 64 Months..... 2 Days..... 11 If less than one day..... hrs. min.

9. Birthplace..... Baltimore County, Md.
 (Town, county, and state)

10. Usual occupation..... at home

11. Industry or business

MOTHER FATHER 12. Name..... Charles A. Freund
 13. Birthplace..... Baltimore County, Md.

MOTHER 14. Maiden name..... Mary Herrman
 15. Birthplace..... Harford County, Md.

16. Informant..... Mrs. Mamie Winter
 Address..... 6200 Hamilton Ave.

17. burial Date thereof..... 5/26/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Zion Lutheran
 Location..... Stemmers Run, Md.

18. Funeral director..... Lassarahn Funeral Home
 Address..... 7401 Belair Rd.

19. May 24 19 48 *May 24*
 (Date filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 24 19 48 at 3 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 19 48 to May 24 19 48 and that I last saw him alive on May 24 19 48

Immediate cause of death..... Coronary occlusion
 DURATION..... Sudden

Due to..... Arterio Sclerotic Cardis
 Vascular disease 1 yr

Due to.....
 Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

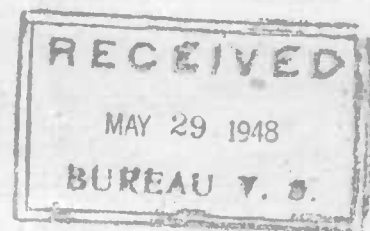
22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Geo M Baumgardner
 M. D. or other
 Address..... 8552 Phila Rd Date signed 5-24-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04692

Reg. Dist. No. 38

1. PLACE OF DEATH: *Balto*
 County *Towson*
 City or town *Towson*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? *3.5 yrs*
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infant, give residence of mother)
 State *Md.* County *Balto*
 City or town *Towson*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. *428 Railroad Ave*
 (If rural, give LOCATION)
 2.(a) If veteran, name war.

3. (a) FULL NAME

Edna & Levia Gardner

3. (b) Social Security Number

4. Sex *FF.* 5. Color or race *Married* 6. Single, married, widowed, or divorced
 6.(b) Name of husband or wife *Charles & Gardner*
 6.(c) If alive, give age *59* years
 7. Birth date of deceased (mo., day, yr.) *June 17th 1891*
 8. AGE: Years *56* Months Days If less than one day
 hrs. min.

9. Birthplace *Rockyville Md.*
 town, county, and state

10. Usual occupation *Housewife*

11. Industry or business

12. Name *Talbert & Waverport*

13. Birthplace *Md.*

14. Maiden name *Eliza Johnson*

15. Birthplace *Md.*

16. Informant *Charles & Gardner*

Address *428 Railroad Ave*

17. Burial Date there *May 26 - 1948*

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematorium *Forest Hill*

Location *Rockyville, Balto, Co. Md.*

18. Funeral director *Byron's Home & Right*

Address *721 N. 2nd St. Balto, 2 - Md.*

19. *May 26 19 48* *a/w. H. H. H.*

(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *May 22* 19 *48* at *11:30* P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *May 14* 19 *48* to *May 22* 19 *48* and that I last saw him alive on *May 22* 19 *48*

Immediate cause of death *Cerebral Hemorrhage*

Due to *3 days*

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE *Louis A. Johnson* M. D. or other

Address *2329 Green St* Date signed *May 27 1948*

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

04693

42

1. PLACE OF DEATH:

County Baltimore

City or town Haltersville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

1806 Selma Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County Patto

City or town Haltersville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1806 Selma Ave
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

William A. Geiss

3. (b) Social Security Number

4. Sex

M

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Mary E. (Schwartz)

7. Birth date of deceased (mo., day, yr.)

Feb. 27, 1873

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

75

2

12

hrs.

min.

9. Birthplace

MD.

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

Sailor

FATHER

12. Name

John J. Geiss

13. Birthplace

Germany

MOTHER

14. Maiden name

Elizabeth Lindenthorpe

15. Birthplace

Germany

16. Informant

Mrs. Mary E. Geiss

Address

1806 Selma Ave

17. Burial

May 12/48

(Burial, cremation, or removal. Which?)

May 12/48

Cemetery or crematory

Lorraine Pk. Mausoleum

Location

Woodlawn, Md.

18. Funeral director

Harry H. Vintzke

Address

4101 Edmondson Ave.

19. 5/11

19 48

(Date rec'd by registrar)

P. W. Hedrick

Registrar

MD.

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 9th 19. 48, at 1:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 19, 47 to May 9th 19. 48

and that I last saw him alive on May 9 19. 48

Immediate cause of death

Cancer of stomach

DURATION

7 Months

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Arthur Dennis

M. D. or other

Address 800 N 33rd St

Date signed 5-10-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Line connect age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Baltimore
 City or town..... Woodbrook
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 20 yrs.
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... md County..... Baltimore
 City or town..... Woodbrook
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... Lyconnell
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Ethel Fairbanks Gibbs

3. (b) Social Security Number

4. Sex..... Female 5. Color or race..... white 6. (a) Single, married, widowed, or divorced..... Married
 6. (b) Name of husband or wife..... John Sears Gibbs Jr.
 7. Birth date of deceased (mo., day, yr.)..... Mar 19 1879 6. (c) If alive, give age..... 70 years
 8. AGE: Years..... 69 Months..... 1 Days..... 24 If less than one day..... hrs. min.

9. Birthplace..... Baltimore Md
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER 12. Name..... William T. Dixon

13. Birthplace..... Balto. Md.

MOTHER 14. Maiden name..... Mary Underduys

15. Birthplace..... Balto Md

16. Informant..... W. T. Dixon Gibbs

Address..... 2 Oak Place Balto 18

17. Burial..... Burial Date thereof..... May 5 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Springhill

Location..... Easton Md

18. Funeral director..... Henry W. Jenkins & Sons

Address..... McCallister & Orchard St

19. 37 48 W. H. Delueh
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 3rd 19. 48, at 1⁰⁰ p. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Oct. 12 19. 43, to May 3rd 19. 48
 and that I last saw her alive on May 3rd 19. 48

Immediate cause of death..... cerebral hemorrhage DURATION..... 5 1/4

Due to..... arterio-sclerosis
generalized cerebral

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury..... Injured at work?

23. SIGNATURE..... Ward B. Allen M. D. or other

Address..... 6 E. Edge St. Balto 2 Date signed..... 5-4-48

Dr. Ward B. Allan
6 E Eager St

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 9 years, 11 months, 5 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 9 years, 11 months, 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 715 North Broadway
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

John Thomas Gray

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced single
 6.(b) Name of husband or wife _____
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) April 10, 1889
 8. AGE: Years 59 Months 1 Days 2 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Maryland
 (Town, county, and state)
 10. Usual occupation None
 11. Industry or business None
 12. Name Gray Sylvanus Gray
 13. Birthplace Maryland
 14. Maiden name Eliza Gray
 15. Birthplace Maryland

16. Informant Hospital records
 Address Catonsville-28, Maryland
 17. Burial Date thereof 5/17/48
 (If burial, cremation, or removal: Which?) (month) (day) (year)
 Cemetery or crematory Baets Cemetery
 Location Baets City
 18. Funeral director Edw. J. MacNabb
 Address Catonsville, Md.
 19. 5/17 19 48 VE. Harry
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 19 48 at 5:15 a. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 7 19 38 to May 12 19 48
 and that I last saw him alive on May 12 19 48

Immediate cause of death Right upper lobar pneumonia DURATION 8 hrs.
Subarachnoid hemorrhage 8 hrs.
 Due to _____
 Due to _____
 Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results as above
 PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE Isadore Tuerk, M.D. M. D. or other _____
 Address Catonsville-28, Md. Date signed 5-13-48

RECEIVED

MAY 20 1911

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:

County Baltimore
 City or town Mount Wilson
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 0 yrs., 3 mos., 24 days
 Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. T. B. Sanatorium
 How long in hospital or institution? 0 yrs., 3 mos., 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County _____
 City or town Baltimore City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 3830 Ferndale Avenue
 (If rural, give LOCATION)
 2. (a) If veteran, name war World War I

3. (a) FULL NAME

Mr. Harry E. Griffith

3. (b) Social Security Number

212-05-6524

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Gertrude Griffith

6. (c) If alive, give age 48 years

7. Birth date of

deceased (mo., day, yr.) November 23, 1899

8. AGE:

Years

Months

Days

If less than one day

48

6

0

hrs. min.

9. Birthplace

Elkridge, Maryland

(Town, county, and state)

10. Usual occupation

Sales Supervisor

11. Industry or business

FATHER
MOTHER

12. Name

Ridgely Griffith

13. Birthplace

Elkridge, Maryland

14. Maiden name

Margaret Stumpner

15. Birthplace

Elkridge, Maryland

16. Informant

Mr. Harry E. GriffithAddress 3830 Ferndale Ave., Balto., Md.

17. Burial

Date thereof May 26, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baltimore National Cemetery

Location

5501 Fred. Ave., Balto., Md.

18. Funeral director

E. W. LamoreauAddress 4510 Liberty Hgts. Ave., Balto., Md.

19. 5/23/

(Date rec'd by registrar)

19 48

Walter R. Meyer

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23, 1948 12:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 29, 1948, to May 23, 1948and that I last saw him alive on May 23, 1948

Immediate cause of death

Pulmonary Tuberculosis

DURATION

4 yrs.

Due to

Tubercle Bacilli

Due to

Other conditions Tuberculous Enteritis6 mos.

(Include pregnancy within 8 months of death)

Major findings of operations

No operation

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

23. SIGNATURE

Stewart S. Shaffer M.D.
M.D. or other _____
Address Mt. Wilson, Md. Date signed 5/23/48

RECEIVED

MAY 27 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04697

37

Reg. Dist. No.

1. PLACE OF DEATH: Baltimore
 County.....
 City or town..... Rural- Cockeysville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 40 years
 Hospital, institution, or street address where death occurred:
Shawan Road
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... Maryland County..... Baltimore
 City or town..... Rural- Cockeysville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... Shawan Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Annie Maria Hall

3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife..... Howard Hall
 6.(c) If alive, give age..... 82 years

7. Birth date of deceased (mo., day, yr.) June 19th 1888
 8. AGE: Years 59 Months 0 Days 0 If less than one day..... hrs. min.

9. Birthplace..... Hartford County, Md.
 (Town, county, and state)
 10. Usual occupation..... Housewife and domestic
 11. Industry or business.....

12. Name..... Lloyd Barnes Robinson
 13. Birthplace..... Hartford County, Md.
 14. Maiden name..... Josephine Rebecca Rainbow
 15. Birthplace..... Hartford County, Md.

16. Informant..... Elaine L. M. Johnson
 Address..... Cockeysville, Md.

17. Burial..... West Liberty
 (Burial, cremation, or removal. Which?)
 Cemetery or crematory..... Hartford Co. Md.
 Location.....

18. Funeral director..... Edw. J. M. Wright
 Address..... 721 Magnolia St. Baltz, Md.
5717
 19. (Date rec'd by registrar)..... 19 48

20. Registrar..... J. W. Reed
 Address.....

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 14 May 19 48, at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19 47 to May 19 48
 and that I last saw her alive on 12 May 19 48
 Immediate cause of death..... Cerebral Accident
 DURATION..... 14 days

Due to..... Hypertension 8 years
 Due to..... Arteriosclerosis 8 years

Other conditions.....
 (Include pregnancy within 3 months of death)
 Major findings of operations.....
 Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town)..... (County)..... (State).....
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

23. SIGNATURE..... Walter T. Kees M.D.
 M. D. or other.....
 Address..... Cockeysville, Md. Date signed..... 14 May 1948

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No.

04698

44

1. PLACE OF DEATH:

County... BaltimoreCity or town... Fort Howard
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hospital, Ft. Howard, Md.How long in hospital or institution? 6 Days

3. (a) FULL NAME

GEORGE L. HAMEL

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Dora Hamel7. Birth date of deceased (mo., day, yr.) 7-14-968. (c) If alive, give age 51 years8. AGE: Years 51 Months 10 Days 11 It less than one day hrs. min.9. Birthplace Baltimore, Md.
(Town, county, and state)10. Usual occupation Guard

11. Industry or business

12. Name John Hamel13. Birthplace Maryland14. Maiden name Catherine Miller15. Birthplace Maryland16. Informant Clinical Records, Vets. Adm. Hosp.Address Ft. Howard, Maryland17. Burial Date thereof 5/28/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baltimore National CemeteryBaltimore, Md.Location Howard N. Blight18. Funeral director Howard Blight, Funeral HomeAddress 4914 Belair Rd., Baltimore, Md.19. may 27 19 48 A. W. Hedrick
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 3124 Woodhome Avenue
(If rural, give LOCATION)2. (a) If veteran, name war WW-I

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25, 19 48 at 2:40 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19, 19 48 to May 25, 19 48
and that I last saw him alive on May 25, 19 48Immediate cause of death MYOCARDIAL FAILURE DURATION 1-1/2 Yrs.Due to Rheumatic Heart Disease 30 Yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results No Autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robt Larner MD M. D. or otherAddress VAH, FT. HOWARD, MD. Date signed 5-25-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04699

Reg. Dist. No. 32

1. PLACE OF DEATH:

County Mt. Wilson, Balto. Co.City or town Mt. Wilson
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 yrs., 3 mos., 29 days.Hospital, institution, or street address where death occurred: Mt. WilsonBranch, Md. T.B. SanatoriumHow long in hospital or institution? 2 yrs., 3 mos., 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 2202 Gough Street
(If rural, give LOCATION)

2(a) If veteran, name war _____

3. (a) FULL NAME

Mr. Ferdinand Hammett

3. (b) Social Security Number

None

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Single</u>
-----------------------	----------------------------------	---

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) May 25, 18888. AGE: Years 59 Months 11 Days 16 If less than one day _____ hrs. _____ min.9. Birthplace Baltimore, Maryland
(Town, county, and state)10. Usual occupation Ambulance Driver

11. Industry or business _____

12. Name Frances D. Hammett13. Birthplace Baltimore, Maryland14. Maiden name Margaret Aheran15. Birthplace Baltimore, Maryland16. Informant Mr. Ferdinand HammettAddress 2202 Gough St., Balto., Md.17. Burial (Burial, cremation, or removal. Which?) May 14, 1948
(month) (day) (year)Cemetery or crematory New Cathedral CemeteryLocation 1300 Old Fred.R., Balto., Md.18. Funeral director Lilly & Zeiler, Inc.Address Eastern Ave. & Wolfe St., Balto., Md.19. May 11, 1948
(Date rec'd by registrar)

Register _____

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11, 1948 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 12, 1946 to May 11, 1948and that I last saw him alive on May 11, 1948

Immediate cause of death _____ DURATION

Pulmonary Tuberculosis 2 Yrs.9 mos.Due to Tubercle bacilli

Due to _____

Other conditions None

(Include pregnancy within 8 months of death)

Major findings of operations No operation

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Stewart S. Shaffer M.D.Address Mt. Wilson, Maryland Date signed 5/11/48

CERTIFICATE OF DEATH

STATE OF NEW YORK

MEDICAL CERTIFICATION

RECEIVED
MAY 17 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04700 42

1. PLACE OF DEATH County <u>Baltimore</u> City or town <u>St. Denis</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>9 mo.</u> Hospital, institution, or street address where death occurred: <u>5121 A. St.</u> How long in hospital or institution? <u>—</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Md.</u> County <u>Baltimore</u> City or town <u>St. Denis</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>5121 A. St.</u> (If rural, give LOCATION) 2.(a) If veteran, name war <u>none</u>			
3.(a) FULL NAME <u>Charles Henry Harrison</u>				3.(b) Social Security Number <u>705-05-6111</u>			
4. Sex <u>Male</u>		5. Color or race <u>White</u>		6.(a) Single, married, widowed, or divorced <u>Married</u>			
6.(b) Name of husband or wife <u>Annie T. (Swann) Harrison</u>				6.(c) If alive, give age <u>61</u> years			
7. Birth date of deceased (mo., day, yr.) <u>Feb 14 1886</u>				8. AGE: Years <u>62</u> Months <u>2</u> Days <u>18</u> If less than one day <u>—</u> hrs. <u>—</u> min. <u>—</u>			
9. Birthplace <u>Baltimore City Md.</u> (Town, county, and state)				10. Usual occupation <u>Prakman</u>			
11. Industry or business <u>M. & O. R.R.</u>				12. Name <u>Robert W. Harrison</u>			
13. Birthplace <u>Baltimore Md.</u>				14. Maiden name <u>Catherine Jones</u>			
15. Birthplace <u>Baltimore Md.</u>				16. Informant <u>Mrs Annie T. Harrison</u> Address <u>5121 A. St. St. Denis</u>			
17. Burial (Burial, cremation, or removal, Which?) <u>Burial</u> Date thereof <u>5/5/48</u> (month) (day) (year) Cemetery or crematory <u>Cedar Hill Cem.</u> Location <u>Balto., Md.</u> <u>WM. J. TICKNER & SONS</u>				18. Funeral director Address <u>Balto., Md.</u>			
19. <u>5/3</u> <u>48</u> (Date rec'd by registrar) 19				20. DATE OF DEATH <u>May 2</u> 19 <u>48</u> at <u>11:20</u> M			
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>Apr 28/48</u> to <u>May 2/48</u> and that I last saw him alive on <u>May 2/48</u>				Immediate cause of death <u>Chronic Bronchitis</u> <u>of a long standing</u> <u>due to</u> <u>Chronic Bronchitis</u> Other conditions <u>—</u> (Include pregnancy within 3 months of death)			
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide <u>—</u> Date of <u>—</u> Where did injury occur? <u>—</u> (City or town) (County) (State) Injured at home, farm, industry, public place (where?) <u>—</u> Means of injury <u>—</u> Injured at work? <u>—</u>				23. SIGNATURE <u>Elbridge</u> Address <u>—</u> Date signed <u>5/3/48</u>			

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baets CoCity or town Catonsville Md
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 27 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)Street No. 12 Eggs Lane
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Burtha M Hayworth

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

W married

8. (b) Name of husband or wife

Wm B Hayworth

7. Birth date of

deceased (mo., day, yr.)

March 16 1875

8. AGE:

Years

Months

Days

If less than one day

73

hrs.

min.

9. Birthplace

W. Va.
(Town, county, and state)

10. Usual occupation

Domestic

11. Industry or business

Home

12. Name

John H Denox

13. Birthplace

W. Va.

14. Maiden name

Mary E Coleman

15. Birthplace

Ind.

16. Informant

Wm B Hayworth

Address

12 Eggs Lane

17. Burial

(Burial, cremation, or removal. Which?)

Meadow Ridge

Cemetery or crematory

Howard Co Md.

Location

Edna S Mac Gabb

18. Funeral director

Catonsville Md.

Address

5/25 48

19. (Date rec'd by registrar)

U.E. Harris

Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 22 May, 1948 19... at 7:28 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 14 19... to 22 May 19... 48and that I last saw him ER alive on 20 May 19... 48

Immediate cause of death

Cachexia Cachexia

DURATION

2 wks

Due to

Carcinoma Rectum withliver METASTASESUnknown

Due to

Atherosclerotic cardiovascular disease - aortic regurgUnknown

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Stephen Lee Magness M.D

M. D. or other

Address 752 Frederick Ave. Date signed 5-23-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 27 1948

BUREAU V. S.

CERTIFICATE OF DEATH

Registered No. 44

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address... 6816 Brentwood Ave
- (c) Hospital or institution:
- (d) Length of stay in hospital or inst. (yrs., mos., or days)
- (e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:

- (a) State... Md. (b) County
- (c) City or town... Baltimore
(If outside city or town limits, write RURAL and give town)
- (d) Street No... 6816 Brentwood Ave
(If rural give location)
- (e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

Laura C. Hilgeman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F.

5. Color or race

W.

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife

Henry Hilgeman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

11/25/79

8. AGE:

Years

Months

Days

If less than one day

68

6

3

hr.

min.

9. Birthplace

Maryland
(Town, county, and state)

10. Usual Occupation

H Housewife

11. Industry or business

at home

FATHER

12. Name

George Reed

13. Birthplace

Md

MOTHER

14. Maiden Name

Mary Mace

15. Birthplace

Md.

16 (a) Informant

Geo. Hilgeman - son

(b) Address

6816 Brentwood Ave

17 (a)

Burial

(b) Date thereof

5/31/48

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Oak Lawn

Location

Eastern Ave Bldg.

18 (a) Funeral director

Jelly & Zehn

(b) Address

403 S. N. 1st St

19 (a) MAY 29 1948

(Date rec'd by registrar)

Wilmington, Delaware

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 27 1948, at 6:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 26 1948, to May 27 1948, and that I last saw her alive on May 27 1948.

Immediate cause of death

Cardiac Failure

Duration

1 Mo

Due to HYPERTENSIVE CARDIOVASCULAR DISEASE

Due to

Other Conditions CARCINOMA OF THE UTERUS

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
- (b) Date of occurrence at M
- (c) Where did injury occur? (City or town) (County) (State)
- (d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature S. J. P. O. Mockenbach
Address 6714 Holabird Ave Date signed 5/28/48

PHYSICIAN

Underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE

cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

Macdonald
6714 4th Ave
Baltimore 1007

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04702

52a

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 32 Days
 Hospital, institution, or street address where death occurred:
Vets. Adm. Hospital, Ft. Howard, Maryland
 How long in hospital or institution? 32 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1307 W. Fayette Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war WW-I

3. (a) FULL NAME

CLINTON H. HOFFMAN

3. (b) Social Security Number

220-12-9897

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife Single
 7. Birth date of deceased (mo., day, yr.) 12-18-1897
 8. AGE: Years 50 Months 4 Days 27 It less than one day _____ hrs. _____ min.
 9. Birthplace West Virginia
 (Town, county, and state)
 10. Usual occupation Painter
 11. Industry or business _____
 12. Name Franklin Hoffman
 13. Birthplace West Virginia
 14. Maiden name Sadie Plum
 15. Birthplace West Virginia

16. Informant Clinical Records, Vets. Adm. Hospital
Fort Howard, Maryland
 Address _____
 17. Removal Date thereof 5-16-48
 (Burial, cremation, or removal to which?) Queens Point Cemetery, Keyser W. Va.
 Cemetery or crematory Rogers Funeral Home
85 S. Maine St., Keyser, W. Va.
 Location Howard Blight, Jr.
4914 Belair Rd., Balto., Md.
 18. Funeral director _____
 Address _____
 19. May 16-48 Dawn L. Harber
 (Date rec'd by registrar) _____ Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15, 1948 at 7:40 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 14, 1948 to May 15, 1948
 and that I last saw him alive on May 15, 1948
 Immediate cause of death Carcinoma of left kidney with metastases to liver
 Due to _____
 Due to _____
 Other conditions None
 (Include pregnancy within 3 months of death)
 Major findings of operations _____ Date of op. _____
 Autopsy results Substantiated above.
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

DURATION

3 Mos.
plus

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State) _____
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE Raymond J. Lipin
RAYMOND LIPIN, M.D. M.D. or other _____
 Address VAH, Ft. Howard, Md. Date signed 5-16-48

RECEIVED

MAY 19 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

04703

468

1. PLACE OF DEATH:

County Baltimore
City or town Owings Mills
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 1/2 yrs.
Hospital, institution, or street address where death occurred: Home.
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Baltimore
City or town Owings Mills
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME

Mrs Ethel McLane Hoffman

3. (b) Social Security Number

?

4. Sex F 5. Color or race W. 6.(a) Single, married, widowed, or divorced divorced

6.(b) Name of husband or wife Richard C. Hoffman Jr.

6.(c) If alive, give age 66 years
7. Birth date of deceased (mo., day, yr.) 17 July 1893

8. AGE: Years 54 Months 10 Days 3 If less than one day hrs. min.

9. Birthplace Bar Harbor Maine
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business none

12. Name William Henry Lawrence Lee

13. Birthplace New York

14. Maiden name Katherine M. McLane

15. Birthplace Maryland

16. Informant Katherine Hoffman

Address Owings Mills, Md.

17. Burial Date thereof 5/22/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Thomas Cem.

Location Garrison Forest Md.

18. Funeral director Wm. J. Tickner & Sons

Address Batts Md.

19. May 24 1948 A. W. Hedrick
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 May 1948 at 8:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1948 to 20 May 1948 and that I last saw her alive on 19 May 1948

Immediate cause of death cardiopulmonary failure DURATION 12 hrs

Due to Recurrent Cancer of Stomach with metastases 16 mos

Due to —

Other conditions none

(Include pregnancy within 3 months of death)

Major findings of operations Cancer of Stomach Date of op. April 15, 47

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul H. Rayce M.D. M. D. or other

Address Pikesville 8, Md. Date signed 20 May 48

MARGIN RESERVED FOR BINDING

VS A16 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04704

Reg. Dist. No. 38

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 years, 9 months, 26 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 4 years, 9 months, 26 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County _____
 City or town Baltimore # 11
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 3526 Clipper Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Annie Hood

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife James Edward Hood (deceased)
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) September 6, 1873
 8. AGE: Years 74 Months 8 Days 4 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Md.
 (Town, county, and state)
 10. Usual occupation Mill worker (retired)
 11. Industry or business Cotton
 12. Name Charles Waxter
 13. Birthplace Germany
 14. Maiden name (first name unknown) Orem
 15. Birthplace Baltimore, Maryland
 16. Informant Hospital Records

Address Catonsville, 28, Maryland
 17. Burial Date thereof May 13, 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory St Mary's
 Location Hempden
 18. Funeral director Paul E. Chensworth Jr.
 Address 3615-17 Chestnut Ave
 19. May 13, 1948 G. W. Dedue
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10, 1948 19____ at 7:45 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15, 1943 19____ to May 10, 1948 19____and that I last saw her alive on May 10, 1948 19____

Immediate cause of death

Right bronchial pneumonia

DURATION

12 hoursDue to Pernicious AnemiaIndefinite

Arteriosclerosis, Generalized
Arteriosclerotic heart disease

Other conditions Bilateral lenticular cataracts

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. _____

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Isadore Tuerk, M. D.

M. D. or other

Address Catonsville, 28, Maryland Date signed 5/10/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. **30**

1. PLACE OF DEATH **Baltimore**
County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....
Hospital, institution, or street address where death occurred:
5160 New Edmondson Blvd.
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State.....**Md.** County.....**Baltimore**
City or town.....**Catonsville**
(If outside city or town limits, write RURAL and give nearest town)
Street No.....**5160 New Edmondson Blvd.**
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3.(a) FULL NAME
Christina B. Hornig

3.(b) Social Security Number

4. Sex **Female** 5. Color or race **W.** 6.(a) Single, married, widowed, or divorced **Married**
6.(b) Name of husband or wife **Paul A. Hornig**
B.(c) If alive, give age.....years
7. Birth date of deceased (mo., day, yr.) **Aug. 22, 1877.**
8. AGE: Years **70** Months **8** Days **16** If less than one day.....hrs.min.

9. Birthplace **Md.**
(Town, county, and state)
10. Usual occupation.....
11. Industry or business.....

12. Name.....**Frederick Stegman**
13. Birthplace.....**Germany**
14. Maiden name.....**Anna-----**
15. Birthplace.....**Germany**

16. Informant.....**Paul A. Hornig**
Address.....**5160 New Edmondson Blvd.**

17. **Burial** Date thereof.....**May 11/48.**
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory.....**New Cathedral**
Location.....**4300 Old Frederick Rd.**

18. Funeral director.....**Harry J. Winkler**
Address.....**4101 Edmondson Ave.**

19. **May 10** 19**48** **V.E. Harry**
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **May 8/48.** 19..... at **2:05 A.** M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
March 19**48** to **May 8** 19**48**
and that I last saw h..... alive on **May 8** 19**48**

Immediate cause of death.....
Carcinoma of ovary, bilateral
DURATION
about 1 year

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of Injury..... Injured at work?

23. SIGNATURE.....**Dr. J. G. M.D.**

M. D. or other

Address.....**1 Willow Hill Ave.,** Date signed.....**5/10/48**

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

RECEIVED
MAY 11 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No.

04706

40

1. PLACE OF DEATH:

County BaltimoreCity or town Rural - Essex
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 weeksHospital, institution, or street address where death occurred:
White Marsh P.O. - Beach Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County BALTO.City or town Rural - Essex
(If outside city or town limits, write RURAL and give nearest town)Street No. Bird River Beach Rd., Whitmarsh
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

James Paul Horsey

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MALE. W. Infant.

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 21 April 19488. AGE: Years Months Days It less than one day
1 30 1 hrs. min.9. Birthplace BALTIMORE Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Eugene Horsey13. Birthplace Denton, Md.14. Maiden name Annabelle Simmons15. Birthplace BALTO. County, Md.16. Informant Mrs. Teresa SimmonsAddress White Marsh P.O.17. Burial Date thereof 5/22/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory BelwoodLocation Balto City Md18. Funeral director Lassah Funeral HomeAddress 7401 Belair Rd.19. 5/22/48 N. M. M. M. M.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 22 May 48 at 8 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

18 MAY 1948 to 22 MAY 1948
and that I last saw h. J. M. alive on 21 MAY 1948

Immediate cause of death

Respiratory failure

DURATION

1 hr.Due to Pneumonia5 daysDue to Virus

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

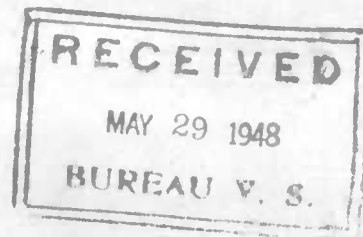
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Wegne of injury Injured at work?

23. SIGNATURE Maxwell H. MunnM. D. openerAddress Essex, Md Date signed 5-22-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04727

1. PLACE OF DEATH:

County Baltimore
City or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Dundalk 22
(If outside city or town limits, write RURAL and give nearest town)
Street No. 214 Patapsco Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

JOHN W. HURLEY

3. (b) Social Security Number

705-10-9744

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Anna King

6.(c) If alive, give age 1 years

7. Birth date of deceased (mo., day, yr.) March 9, 1874

8. AGE: Years 74 Months 2 Days 1 If less than one day hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business Railroad

12. Name Arthur Hurley

13. Birthplace Maryland

14. Maiden name Margaret (?)

15. Birthplace Pa.

16. Informant Anna Hurley

Address 214 Patapsco Ave. Dundalk, Md.

17. Burial Date thereof 5 13 48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Sacred Heart

Location German Hill Road

18. Funeral director Lilly and Zeiler, Inc.

Address 403 S. Wolfe St. Balto. 31, Md.

19. May 11 19 48 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 19 48 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19____ to _____ 19____

and that I last saw him _____ alive on _____ 19____

Immediate cause of death Crown Occlusion

Due to A-S-C-V Disease

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE M. Davis

Address Dundalk, Md.

Date signed May 11 19 48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 93d 04708 38

1. PLACE OF DEATH County <u>Towson</u> City or town <u>Towson</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: How long in hospital or institution?				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>md</u> County <u>Towson</u> City or town <u>Towson</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>441 Penna. Ave.</u> (If rural, give LOCATION) 2.(a) If veteran, name war			
3. (a) FULL NAME <u>Rachel Jackson.</u>				3. (b) Social Security Number			
4. Sex <u>male</u>		5. Color or race <u>C</u>		6. (a) Single, married, widowed, or divorced <u>Widow</u>		MEDICAL CERTIFICATION	
8. (b) Name of husband or wife <u>Benjamin A. Jackson</u>				20. DATE OF DEATH <u>May 26th</u> 19 <u>48</u> , at <u>10³⁰</u> P.M.			
7. Birth date of deceased (mo., day, yr.) <u>June 22, 1880</u>				21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>May 21st</u> 19 <u>48</u> , to <u>May 26th</u> 19 <u>48</u> and that I last saw her alive on <u>May 26th</u> 19 <u>48</u>			
8. AGE: Years <u>67</u> Months <u>11</u> Days <u>2</u>		6. (c) If alive, give age years		Immediate cause of death <u>Cerebral Hemorrhage</u> <u>(left sided Hemiplegia)</u> Due to <u>benign Arterio Sclerosis</u> <u>Chronic Myocardial Insufficiency</u>		DURATION <u>7 yrs.</u> <u>7 yrs.</u>	
9. Birthplace <u>Towson, Md.</u> (town, county, and state)				Due to <u>Chronic Myocardial Insufficiency</u>			
10. Usual occupation <u>Housewife</u>				Other conditions			
11. Industry or business				(Include pregnancy within 3 months of death)			
12. Name <u>James H. Bond</u>		13. Birthplace <u>Towson Co. Md.</u>		Major findings of operations			
14. Maiden name <u>Emma Williams</u>		15. Birthplace <u>Towson, Co. Md.</u>		Date of op.			
16. Informant <u>Mrs. Mary Jackson</u> Address <u>441 Penna. Ave. Towson</u>				Autopsy results			
17. Burial (Burial, cremation, or removal, Which?) <u>Burial</u> Date thereof <u>May 30, 1948</u> (month) (day) (year) Cemetery or crematory <u>Mt. Zion</u> Location <u>Towson County Md.</u>				PHYSICIAN: Please underline the cause to which death should be charged statistically.			
18. Funeral director <u>Mrs. Katie R. Williams</u> Address <u>322 N. Schroeder St.</u>				22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of..... Where did injury occur? (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury Injured at work?			
19. <u>5/29</u> <u>48</u> <u>ASW Hedrick</u> (Date rec'd by registrar) (year) (month) (day) Registrar				23. SIGNATURE <u>Deane L. J. Jones</u> <u>Towson Md.</u> M. D. or other Address..... Date signed <u>5/27/48</u>			

7 17
1948-~~5~~-24

67-11-2

1880-6-24

CRIMINAL CASE OR DEATH

EVOLVED STATE DIVISION OF INVESTIGATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

04709

38-

1. PLACE OF DEATH:

County Baltimore
 City or town Towson 4, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Since May 10, 1948
 Hospital, institution, or street address where death occurred:
Eudowood Sanatorium, Towson 4, Md.
 How long in hospital or institution? Since May 10, 1948

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore County
 City or town Parkton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Carroll A Jacoby

3. (b) Social Security Number

213-14-9577

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Frances Jacoby
 7. Birth date of deceased (mo., day, yr.) August 18, 1920 6. (c) If alive, give age 27 years
 8. AGE: Years 27 Months 08 Days 29 If less than one day _____ hrs. _____ min.

9. Birthplace Gray Michigan
(Town, county, and state)10. Usual occupation Plasterer

11. Industry or business _____

12. Name Arthur W Jacoby
 13. Birthplace Unknown
 14. Maiden name Jodie P. Wheeler
 15. Birthplace Unknown

16. Informant Personal history-Hospital recordsAddress Eudowood Sanatorium, Towson 4, Md.17. Burial Date thereof May 20, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Forreston CemeteryLocation Upperco, Balto. Co., Md.18. Funeral director Jacob HartensteinAddress New Freedom Pa.19. May 19 1948 Charles L. Fiedler
(Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1948 at 2 P. M.

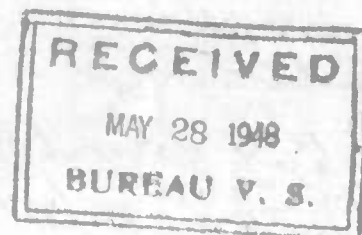
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10 1948 to May 17 1948
 and that I last saw him alive on May 17 1948
 Immediate cause of death _____

DURATION
Tuberculous meningitis Since March
Tuberculosis infection 15
1948
 Due to _____
 Due to _____
 Other conditions Pulmonary tuberculosis Since 1943
 (Include pregnancy within 3 months of death)

Major findings of operations _____
Date of op. _____Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

23. SIGNATURE W A Bridges M. D. or other _____
 Address Towson 4, Md. Date signed 5-17-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:

County BaltimoreCity or town Turners Station
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
561 New Pittsburg Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 1201 Argyle Ave.
(If rural, give LOCATION)

2.(d) If veteran, name war

3.(a) FULL NAME

ESSIE LURRETTA JOHNSON

3.(b) Social Security Number

4. Sex

Female

5. Color or race

Colored

6.(a) Single, married, widowed, or divorced

Widow

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) May 26, 1889

6.(c) If alive, give age years

8. AGE: Years 59 Months 0 Days 0
If less than one day
.....hrs.min.9. Birthplace Reisterstown, Maryland
(Town, county, and state)10. Usual occupation Cook

11. Industry or business

12. Name W. Foster13. Birthplace Md.14. Maiden name Jannie Johnson15. Birthplace Md.16. Informant Mr. Thornton CooperAddress 561 New Pittsburg Ave.17. Burial Date thereof 5-30-48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Luke Cem.Location Reisterstown, Md.18. Funeral director Mrs. Frances A. HemsleyAddress 578 W. Biddle St.19. may 28 48 A. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1948 at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 5 1948 to May 26 1948and that I last saw him alive on May 26 1948Immediate cause of death Coronary Thrombosis

DURATION

24 hours

Due to

Due to

Other conditions Hypertensive Heart Disease

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John C. Oak, M.D. M. D. or otherAddress 140 Oak Ave Date signed 5-26-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County... Baltimore

City or town... Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
6 Enjay Ave.

How long in hospital or institution?

3. (a) FULL NAME

John B. Jones

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Baltimore

City or town... Catonsville
(If outside city or town limits, write RURAL and give nearest town)Street No... 6 Enjay Ave.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Nettie H.

7. Birth date of deceased (mo., day, yr.) October 28, 1874

8. AGE: Years 73 Months 6 Days 24 It less than one day hrs. min.

9. Birthplace... North Carolina
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

12. Name John Jones

13. Birthplace North Carolina

14. Maiden name Belle Womache

15. Birthplace North Carolina

16. Informant Arthur B. Jones

Address 6 Enjay Ave.,

17. Burial Date thereof May 25, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Lorraine Park

Location Baltimore,

18. Funeral director George A. Farley

Address Catonsville, Md.

19. May 24, 1948 V.E. Harry Registrar
(Date read by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22, 1948 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 4, 1948, to May 22, 1948, and that I last saw him alive on May 22, 1948.

Immediate cause of death Cerebral Hemorrhage

DURATION

1 day

Due to Cerebral Arterio Sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James H. Stourel M. D. or other

Address Catonsville Date signed 5/24



Evidence for change of
birthdate shown on
Film G116 5/20/48 dm

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH
County Balto.
City or town Balto. #6 Rosedale 14.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
5302 McCormick Ave.
How long in hospital or institution? 10

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Same
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5302 McCormick Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Jacob George Kahler. 3. (b) Social Security Number

4. Sex Male M. 5. Color or race White 6. (a) Single, married, widowed, or divorced
6. (b) Name of husband or wife Emma (decd)

7. Birth date of deceased (mo., day, yr.) January 15, 1875 6. (c) If alive, give age years
Jan 20/1873

8. AGE: Years 73 Months 3 Days 10 If less than one day
hrs. min.

9. Birthplace Md. (Town, county, and state)

10. Usual occupation Retired

11. Industry or business Painter

12. Name Unknown

13. Birthplace Unknown

14. Maiden name Unknown

15. Birthplace Miss Dorothy Barton Jeller

16. Informant 5302 McCormick Ave. (Niece)

17. burial Date thereof 5/12/48
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Mt. Carmel
Location Baltimore, Md.

18. Funeral director Larsen Funeral Home
Address 7401 Belair Rd.

19. May 11 1948 Registrar W. H. Melch
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 1948 at 10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19 to 19
and that I last saw him alive on 19

Immediate cause of death Coronary accident

Due to Heart seen 5/7/48

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. H. Melch M.D. or other
Address Balto. Co. Dundalk Date signed 5/10/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlea St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 04713 43

1. PLACE OF DEATH: Baltimore

County.....
City or town..... Overlea, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland..... County..... Baltimore.....

City or town..... Overlea, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 14 E. Overlea Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

ANDRIES KARSSEBOOM

3. (b) Social Security Number

172-05-3521

4. Sex male	5. Color or race white	6.(a) Single, married, widowed, or divorced married
----------------	---------------------------	--

6.(b) Name of husband or wife..... Dina Karsseboom

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Sept. 16th, 1876

8. AGE:	Years	Months	Days	If less than one day
	71	7	16 hrs. min.

9. Birthplace..... Holland
(Town, county, and state)

10. Usual occupation..... Paint Mixer

11. Industry or business..... Liberty Can Co.

12. Name..... Andries Karsseboom

13. Birthplace..... Holland

14. Maiden name..... Margarite A. Oldenburg

15. Birthplace..... Holland

18. Informant..... Mrs. A. Karsseboom

Address..... 14 E. Overlea Ave.

17. burial Date thereof 5/6/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Parkwood

Location..... Baltimore, Md.

18. Funeral director..... Lassahn Funeral Home

Address..... 7401 Belair Rd.

19. 5/3 48 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 2nd, 1948 at 10:33 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

June 6 1947 to May 2 1948
and that I last saw him alive on May 2 1948

Immediate cause of death.....

DURATION

Toxic absorption 4 days

Due to..... Neuro. sarcoma

Due to..... of Rt. Groin 1 yr.

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... S. E. Co. B. Co.

M. D. or other

Address..... 14 E. Overlea Ave. Date signed 5/3/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04714

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 25 yrs.
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 3 Paradise Ave
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mae Aileen Katzenberger

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widow6.(b) Name of husband or wife William Katzenberger

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) June 9-1871

8. AGE:

Tears

Months

Days

If less than one day

761116

hrs.

min.

9. Birthplace

Iowa

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

Timoleum O. Johnston

13. Birthplace

Ill.

14. Maiden name

Mary E. Shockley

15. Birthplace

Iowa

16. Informant

Dr. James W. Katzenberger

Address

3 Paradise Ave, Catonsville

17.

(Burial, cremation, removal, Which?)

Date thereof

May 28-1948
(month) (day) (year)

Cemetary or crematory

New Cathedral

Location

Baltimore, Md

19. Funeral director

Geo. D. Beyer Jr

Address

1512 Hollins St

19.

(Date rec'd by registrar)

5/27/48V.E. Harris

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

25 May48

at

2 A

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan.1946

to

25 May48

and that I last saw her

alive on

24 May48

Immediate cause of death

Coronary Thrombosis

DURATION

Acute

Due to

Coronary SclerosisSeveral yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

R. H. Allison

M. D. or other

Address

4 Burleigh St. Towson

Date signed

25 May 48

RECEIVED

MAY 29 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No.

04715

38

1. PLACE OF DEATH:

County..... BaltimoreCity or town..... Stonedeigh
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Ind County.....City or town..... Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 805 Wellington Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

3. (a) FULL NAME

Cuthus L. Keller

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Eustus E.

7. Birth date of deceased (mo., day, yr.)

Sept 15 1896

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

51

..... hrs. min.

9. Birthplace

Dayton Ohio
(Town, county, and state)

10. Usual occupation

Business man

11. Industry or business

Machinery & tools

MOTHER FATHER

12. Name

Thomas L. Keller

13. Birthplace

Dayton Ohio

14. Maiden name

Francis Kessler

15. Birthplace

Dayton Ohio

16. Informant

Thomas L. Keller

Address

Dayton Ohio

17.

(Burial, cremation, or removal. Which?)

Date thereof

May 8 1948
(month) (day) (year)

Cemetery or crematory

Grand Ridge Cem

Location

Pikesville

18. Funeral director

John A. Moran

Address

3000 E. Baltimore St

19.

(Date rec'd by registrar)

19

48

A. W. Helmer

Registrar

2

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 6

19

48, at 9:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 4

19

47 toMay 6

19

48and that I last saw him alive on May 5

19

48

Immediate cause of death

Cerebral hemorrhage
(malignant)

Due to

Brain tumor, left
cerebrum, glioma

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Harry F. Klunfeldt

M. D. or other

Address

1101 St. Paul St.

Date signed

May 6, 1948

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

04716

40

1. PLACE OF DEATH:

County BaltimoreCity or town Loseley
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Baltimore County BaltimoreCity or town Loseley Ind
(If outside city or town limits, write RURAL and give nearest town)Street No. Loseley Ind
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Bernard J. Kelley

3. (b) Social Security Number

216-01-19584. Sex M 5. Color of race W 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Marie C. Kelley7. Birth date of deceased (mo., day, yr.) Oct 31 1894 6. (c) If alive, give age _____ years8. AGE: Years 53 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Pa
(Town, county, and state)10. Usual occupation National Bureaucracy

11. Industry or business

12. Name John B. Kelley13. Birthplace Pa14. Maiden name Eleanor Brown15. Birthplace Pa16. Informant Marie C. KelleyAddress Loseley Ind.17. Burial Date thereof May 8 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Oak Lawn CenLocation Eastern Ave Road18. Funeral director John A. MoranAddress 3000 E Baltimore St19. May 6 1948 A. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 19 48 at 3:03 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 4 19 48 to May 4 19 48and that I last saw him alive on May 4 19 48Immediate cause of death Crown aneurysmbasal

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE F. W. Wehmer Jr.Address 42 Edgewater Cpt. Bldg., Balt. 11 Ind. Date signed May 8 1948

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Do not correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04717

Reg. Dist. No.

1. PLACE OF DEATH:

County... BALTIMORECity or town... ROSEMONT
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

2912 LOUISIANA AVE.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MD. County... BALTIMORECity or town... (ROSEMONT)
(If outside city or town limits, write RURAL and give nearest town)Street No... 2912 LOUISIANA AVE.
(If rural, give LOCATION)

2.(a) If veteran, name war...

3. (a) FULL NAME

DOROTHY KELLEY

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

MARRIED

6.(b) Name of husband or wife

EDWARD KELLEY

7. Birth date of deceased (mo., day, yr.)

MARCH 31, 1906

8. AGE: Years Months Days If less than one day

4244 years

9. Birthplace

NEW JERSEY
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

12. Name

RALPH LEE

13. Birthplace

NEW JERSEY

14. Maiden name

GERTRUDE STILES

15. Birthplace

NEW JERSEY

16. Informant

MR. EDWARD KELLEY

Address

2912 LOUISIANA AVE.17. BURIAL Date thereof... 5/13/48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

GLEN HAVEN

Location

RITCHIE HIGHWAY

18. Funeral director

JOHN F DENNY, INC.

Address

715 LIGHT ST -3019. May 11 19 48 A. J. Haddock Registrar

(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH... 5/9/48 at 12:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4/10 1938 to 5/9 1948and that I last saw him alive on 5/9 1948

Immediate cause of death

Acute Cardiac FailureDue to Cardiovascular Renal DiseaseDue to Platelet Thrombosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Joseph E. Lawler, M.D.Address 879 Washington Blvd Date signed 5/19/48

DR LAURAITIS

8:30 AM TO 10 AM

6 TO 9 PM

679 WASH BLVD.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04718

Reg. Dist. No. 42

1. PLACE OF DEATH:

County BaltoCity or town Arbutus
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 yr

Hospital, institution, or street address where death occurred:

3204 Rosalie Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltoCity or town Arbutus
(If outside city or town limits, write RURAL and give nearest town)Street No. 3204 Rosalie Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war World War #2

3. (a) FULL NAME

Richard Henry Kelley

3. (b) Social Security Number

213-03-50844. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Clara M. KelleyOct 11, 1944 6. (c) If alive, give age 134 years7. Birth date of deceased (mo., day, yr.) Oct 11, 19118. AGE: Years 36 Months 7 Days 7 If less than one day9. Birthplace Baltimore, Md.
(Town, county, and state)10. Usual occupation Telegraph Operator11. Industry or business B. & O. R. R.12. Name George W. Kelley13. Birthplace Balto. County, Md.14. Maiden name Helen J. Beall15. Birthplace Fredrick County, Md.16. Informant Clara M. KelleyAddress 3204 Rosalie Rd.17. Burial Date thereof 5/22/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory U. S. NationalLocation Balto. Md.18. Funeral director William Cook Inc.Address 1217 St. Paul St.19. 579 48 DAVID
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 19 48 at 6:15 A.M.21. I CERTIFY that death occurred on the date above stated; that deceased deceased fromDec 6 19 47 to May 18 19 48and that I last saw him alive on Aug 13 19 48Immediate cause of death Coronary Thrombosis

DURATION

5 hrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. H. H. H.

M. D. or other

Address 1711 Belm Ave. Date signed 5/2/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04719

1. PLACE OF DEATH:

County BaltimoreCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Baltimore City
(If outside city or town limits, write RURAL and give nearest town)Street No. 1502 W. Baltimore St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Lena J. KENDALL

3. (b) Social Security Number

212-16-3968

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

female white widowed6. (b) Name of husband or wife Edward H. Kendall7. Birth date of deceased (mo., day, yr.) March 4-18688. (c) If alive, give age 8 years

8. AGE:

Years

Months

Days

If less than one day

80210— hrs. — min.

9. Birthplace

Baltimore, Maryland
(Town, county, and state)

10. Usual occupation

Paper Worker

11. Industry or business

Hicks Company Paper Co

12. Name

John Gilbert

13. Birthplace

Germany

14. Maiden name

unknown

15. Birthplace

Germany

16. Informant

Emma A. Roberts

Address

1502 W. Baltimore St.17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

May 1948
(month) (day) (year)

Cemetery or crematory

Knickerbocker Park

Location

Baltimore, Md

18. Funeral director

F. B. Wickett & Son

Address

1300 East Ave19. 5/18

(Date filed by registrar)

19. 481948194819481948194819481948194819481948

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1948 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 9 1948 to May 14 1948
and that I last saw him alive on May 14 1948

Immediate cause of death

Coronary Heart Failure

DURATION

Due to

Hypertensive
cardio-vascular

Due to

diarrhea

Other conditions

Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Milton J. J. J.

M. D. or other

Address

1429 W. Fayette St.Date signed 5/17/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04720 38

1. PLACE OF DEATH:

County BALTO.
City or town ROGERS FORGE
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? _____
Hospital, institution, or street address where death occurred: _____
How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State MD County BALTO
City or town ROGERS FORGE
(If outside city or town limits, write RURAL and give nearest town)
Street No. 221 DUMBARTON RD.
(If rural, give LOCATION)
2. (a) If veteran, name war No

3. (a) FULL NAME

MARTHA JANE RIGHT

3. (b) Social Security Number

No

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced SINGLE

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) JULY 9, 1872

8. AGE: Years 75 Months 10 Days 2 If less than one day _____ hrs. _____ min.

8. Birthplace WESTERNPORT, MD
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name JAMUEL RIGHT
13. Birthplace KID

14. Maiden name LUVENIA A. MICHAEL

15. Birthplace MD.

16. Informant MRS. CLARENCE H. NORRIS (SISTER)

Address 221 DUMBARTON RD

17. REMOVAL Date thereof MAY 14, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory QUEEN'S POINT

Location HEYSER, W. Va.

18. Funeral director Wm T. Tichner & SONS

Address BALTO, MD

19. 5/12 18 XP Alfred Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/11 1948 at 7:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____ to _____ 19____

and that I last saw him _____ alive on _____ 19____

Immediate cause of death Coronary thrombosis, probable

Due to arteriosclerosis coronary arteries

Due to _____

Other conditions Patient was dead on my arrival
(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Samuel T. R. Renell, M.D.

Address 11 E. Chase St. Balt., Md. Date signed May 12, 1948

MARGIN RESERVED FOR BINDING

I

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH *92d*Reg. Dist. No. *30*

04721

1. PLACE OF DEATH:

County..... *Baltimore*
 City or town..... *Catonsville 28, Md.*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... *9 years*
 Hospital, institution, or street address where death occurred.....

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... *Maryland* County..... *Baltimore*
 City or town..... *Catonsville 28*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. *122 Cherrydell Road*
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Robert Johnson King Sr.

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widower

6. (b) Name of husband or wife

Clara Ewing King

7. Birth date of

deceased (mo., day, yr.)

February 28, 1870.

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

*78**2**23*

hrs.

min.

9. Birthplace

Frederick Co., Maryland

(Town, county, and state)

10. Usual occupation

Manager of A.P. Store

11. Industry or business

Retired

FATHER

12. Name

Frederick King

13. Birthplace

Maryland

MOTHER

14. Maiden name

Mary Bowers

15. Birthplace

Maryland

18. Informant

Mrs. Charles Saloman

Address

122 Cherrydell Rd. Catonsville 28, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

5 / 23 / 48

Cemetery or crematory

St. John's Cemetery

Location

Ellicott City, Maryland

19. Funeral director

Easton, Sons

Address

608 Frederick Ave. Catonsville 28, Md.

19.

(Date rec'd by registrar)

19

*48**V.E. Harry*

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 21, 1948, at 4:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*March 1948 to 20 May 1948*and that I last saw him alive on *20 May 1948*

Immediate cause of death

Acute Cardiac dilation

DURATION

Immediate

Due to

*Ch. Myocarditis**years*

Due to

*Valvular heart disease**years*

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Charles J. Timmerman M.D.

M. D. or other

Address

*900 W. Lombard St.*Date signed *21 May 48*

UNITED STATES DEPARTMENT OF JUSTICE

CERTIFICATE OF DEATH

IN THE DISTRICT OF COLUMBIA

DEPARTMENT OF HEALTH

RECEIVED
MAY 24 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County..... Baltimore
 City or town..... Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 29 days
 Hospital, institution, or street address where death occurred:
Dwy Hall Garrison Ave.
 How long in hospital or institution? 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Pa. County.....
 City or town..... Williamstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Peter Kniatkowski

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed8. (b) Name of husband or wife Tonda Kniatkowskinee Rucinski

8. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

1888

8. AGE:

Years

Months

Days

If less than one day

60

..... hrs. min.

9. Birthplace

Poland

(Town, county, and state)

10. Usual occupation

Grocer (Retired)

11. Industry or business

FATHER

12. Name

Unknown

13. Birthplace

Poland

MOTHER

14. Maiden name

Unknown

15. Birthplace

Poland

16. Informant

Mrs Helen OhmmerisAddress 58 Honeycomb Rd. Balto. 20. ind.17. Burial

(Burial, cremation, or removal. Which?)

Date thereof May 7 - 48

(month) (day) (year)

Cemetery or crematory

Location

Williamstown, Pa

18. Funeral director

Thos G. Connolly

Address

418 Eastern Ave - Cranes19. May 7

(Date rec'd by registrar)

19. 48Thos G. Connolly

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 719. 48, at 7:30 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 519. 48, to May 7

and that I last saw him alive on

May 719. 48

Immediate cause of death

Uremia

DURATION

2 weeks

Due to

Chronic glomerulo-nephritis15 years

Due to

Other conditions

Hypertensive C.V. disease15 years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

A. L. Kolodny

M.D. or other

Address

45 Edgewater Apts.Date signed May 7

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1948
1888

RECEIVED
JUN 7 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04722

1. PLACE OF DEATH:

County BaltoCity or town Colgate
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death

Hospital, institution, or street address where death occurred:

534 S. 48th St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County BaltoCity or town Colgate
(If outside city or town limits, write RURAL and give nearest town)Street No. 534 S. 48th St
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Kasper Gloes

3. (b) Social Security Number

4. Sex

M

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

Margaret

7. Birth date of deceased (mo., day, yr.)

March -25-1891

6. (c) If alive, give age years

8. AGE:

77

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Germany
(Town, county, and state)

10. Usual occupation

Butcher

11. Industry or business

Retired

12. Name

Andrew Gloes

13. Birthplace

Germany

14. Maiden name

Martha Unknown

15. Birthplace

Germany

16. Informant

Mrs. Margaret Gloes

Address

534 S. 48th St

17.

(Burial? cremation, or removal, Which?)

Burial

Date thereof

5-19-48
(month) (day) (year)

Cemetery or crematory

Mt Carmel

Location

O'Donnell St Rd.

18. Funeral director

John B Connolly

Address

448 Eastern Ave.

19.

(Date rec'd by registrar)

May 19 48John B Connolly
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 19 48 at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 14 19 48 to May 15 19 48and that I last saw him alive on May 15 19 48

Immediate cause of death

Coronary Occlusion

DURATION

1 day

Due to

Arterio-sclerotic

Due to

cardio-vascular dis.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Joseph Michi 3D
M. D. or other

Address

448 Eastern Ave

Date signed

5/18/48

RECEIVED
MAY 20 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 36

1. PLACE OF DEATH:

County Baltimore Recedo Knoll
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 Days
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution? 6 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Elizabeth A. Knecht

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) August 7, 1857 6. (c) If alive, give age _____ years

8. AGE: Years 90 Months 9 Days 19 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Maryland
 (Town, county, and state)

10. Usual occupation None

11. Industry or business _____

FATHER 12. Name John A. Knecht, Sr.
 13. Birthplace Germany

MOTHER 14. Maiden name Mary Hoover
 15. Birthplace Maryland

16. Informant Alphonse F. Knecht
 Address 1400 Mt. Royal Avenue

17. Burial Burial Date thereof 5/28/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory New Cathedral
Baltimore, Md.
 Location _____

18. Funeral director W. W. Meates and Son
 Address 805 N. Calvert Street

19. May 27, 48 (Date rec'd by registrar) Registrar [Signature]

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1948 at 230 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1948 to May 26, 48 and that I last saw him alive on May 20, 1948

Immediate cause of death Coronary Thrombosis

Due to Arteriosclerosis

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op' _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Frank J. Gragley MD
3042 N. Calvert St M.D. or other _____
 Address _____ Date signed 5/26/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:

County BaltimoreCity or town Randallstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 Yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Randallstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. McDonough Road

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME

Ella Marie Krebs

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife William H. Krebs6. (c) If alive, give age 58 Yrs. years

7. Birth date of

deceased (mo., day, yr.) August 5 1897

8. AGE:

Years

50

Months

9

Days

8

If less than one day

min.9. Birthplace Baltimore City, Maryland

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Benjamin Swan13. Birthplace Baltimore Md.14. Maiden name Carolyn Mertz15. Birthplace Baltimore, Md.16. Informant Mr. William H. Krebs (Husband)Address McDonough Road, Randallstown, Md.17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 5/17/48

(month) (day) (year)

Cemetery or crematory Mt. OliveLocation Randallstown, Balto: Co. Md.18. Funeral director George J. Ruth, Inc.Address 1735 Harford Avenue19. 5-14- 19 48 Dr. E. E. Nichols

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH May 13th., 19 48 at 10A M

CERTIFY that death occurred on the date above stated; that I attended deceased from

May 13 19 47, to May 13 19 48and that I last saw him alive on May 12 19 48

Immediate cause of death

Cerebral hemorrhage

DURATION

Due to arterial hypertension - 8 months years

Due to

Other conditions

None

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

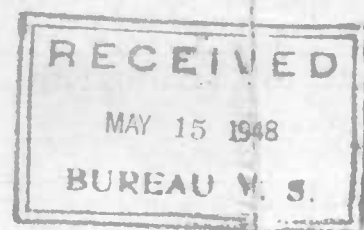
23. SIGNATURE

Dr. E. E. Nichols M.D. or otherAddress Pikesville 8 MdDate signed 5/14/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

04726

43

1. PLACE OF DEATH:

County..... Baltimore
 City or town..... Rural, Raspeburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 3 years
 Hospital, institution, or street address where death occurred:
 1218 64th Street
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County..... Baltimore
 City or town..... Rural, Raspeburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 1218 64th Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

STANISLAUS KWIATKOWSKI

3. (b) Social Security Number

4. Sex..... Male
 5. Color or race..... White
 6.(a) Single, married, widowed, or divorced..... Widowed
 6.(b) Name of husband or wife..... Stanislaw
 6.(c) It alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... (Unknown) 1986
 8. AGE: Years..... 62 ? Months..... Days..... If less than one day..... hrs. min.

9. Birthplace..... Poznan, Poland
 (Town, county, and state)
 10. Usual occupation..... None
 11. Industry or business.....

FATHER
 12. Name..... Maciej Kwiatkowski
 13. Birthplace..... Poznan, Poland
 MOTHER
 14. Maiden name..... Unknown
 15. Birthplace..... Poland

16. Informant..... Mr. George Harne
 Address..... 1218 64th Street

17. Burial..... Date thereof..... May 11 1948
 (Burial, cremation, or removal. Which?)..... (month) (day) (year)
 Cemetery or crematory..... St. Stanislaus
 Location..... Mt. Carmel Road

18. Funeral director..... M. F. Sadowski & Sons
 Address..... 1808 Eastern Avenue

19. (Date rec'd by Registrar)..... 19 48
 Registrar.....

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 7 1948, at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 45 to May 7 1948

and that I last saw him alive on May 7 1948

Immediate cause of death..... Coronary Thrombosis
 DURATION..... 2 days

Due to.....

Due to.....

Other conditions..... Sudden

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... J. H. Green M.D.

Address..... 3400 E. Baltimore Date signed..... 5/10/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
VAH. Fort Howard, Maryland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 3800 Fairhaven Avenue

(If rural, give LOCATION)

Retired

2.(a) If veteran, name war

3. (a) FULL NAME

DWIGHT B. LANDRETH

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

MaleMaleMarried6.(b) Name of land or wife Marie Landreth7. Birth date of deceased (mo., day, yr.) 10-29-05 6.(c) If alive, give age 38 years8. AGE: Years Months Days If less than one day
42 6 8 hrs. min.9. Birthplace North Carolina
(Town, county, and state)10. Usual occupation Unemployed

11. Industry or business

12. Name Peter Landreth (deceased)13. Birthplace North Carolina14. Maiden name Sallie Lake15. Birthplace North Carolina16. Informant Clinical Records, Vets. Adm. Hosp.Address Fort Howard, Maryland17. Burial Date thereof 5/11/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baltimore National CemeteryLocation Baltimore, Maryland18. Funeral director John F. DennyAddress 115 Light St., Baltimore, Md.19. 5/11 48 A. H. Nedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 19 48 at 3:52 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to..... 19.....

and that I last saw him alive on May 7 19 48Immediate cause of death CEREBRAL ACCIDENTDURATION
UnknownDue to Hypertensive vascular disease Unknown

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. H. Saunders

J. H. SAUNDERS, M. D. M. D. or other

Address V.A.H. FT. HOWARD, MD. Date signed 5-8-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0472843

1. PLACE OF DEATH:

Baltimore
County.....
City or town..... Raspeburg, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... life
Hospital, institution, or street address where death occurred:
7500 Philadelphia Road
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State..... Maryland County..... Baltimore
City or town..... Raspeburg, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No..... 7500 Philadelphia Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

Conrad John Langenfelder

3. (b) Social Security Number

214-26-7966

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife..... Emma P. Langenfelder

7. Birth date of deceased (mo., day, yr.)

Feb. 15th, 1877

8. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

71310

..... hrs.

..... min.

9. Birthplace..... Baltimore County, Md.

(Town, county, and state)

10. Usual occupation..... Contractor

11. Industry or business.....

12. Name..... George H. Langenfelder13. Birthplace..... Baltimore County, Md.14. Maiden name..... Lena Long15. Birthplace..... Germany16. Informant..... Mrs. C.J. LangenfelderAddress..... 7500 Philadelphia Rd.17. burial Date thereof..... 5/28/48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory..... Zion LutheranLocation..... Stemmers Run, Md.18. Funeral director..... Lassahn Funeral HomeAddress..... 7401 Belair Rd.19. May 26 19 48 Mrs. A. L. Reifman

(Date filed by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 25 19 48 at 2:41 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 19 19 47 to May 25 19 48and that I last saw him alive on May 25 19 48Immediate cause of death..... Coronaryocclusion

DURATION

SuddenDue to..... Arterio-scleroticcardio-vascular disease1 yr.

Due to.....

Other conditions..... Diabetes MellitusDiabetes Gangrene1 yr.

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Geo. M. Baumgardner

M. D. or other

Address..... Balto 6 Md Date signed..... 5-25-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 29 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH: **Baltimore**
 County **Baltimore**
 City or town **Relay, Md.**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? **Two months and 24 days**
 Hospital, institution, or street address where death occurred:
Relay Sanitarium
 How long in hospital or institution? **Two months and 24 days**

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State **Colorado** County **Monte**
 City or town **Rockville, Md.**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3.(a) FULL NAME

Caroline E. Gage LAWRENCE

3.(b) Social Security Number

4. Sex **female** 5. Color or race **white** 6.(a) Single, married, widowed, or divorced **widowed**
 6.(b) Name of husband or wife **James Lawrence**
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) **Oct. 7/ 1868**
 8. AGE: Years **79** Months **7** Days **16** If less than one day _____ hrs. _____ min.

9. Birthplace **Buffalo New York**
 (Town, county, and state)

10. Usual occupation **Housewife**

11. Industry or business

FATHER 12. Name **Lyman H. Gage**
 13. Birthplace **New York**

MOTHER 14. Maiden name **Lyllis E. Hawkins**
 15. Birthplace **Vermont**

Son- 16. Informant **Mr. Watson Thomas**
 Address **2001 E. 1st Avenue-Denver, Col.**

17. **Burial** Date thereof **May 27/48**
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory **Oak Woods Cemetery**
 Location **Chicago Ill**

18. Funeral director **John O. Mitchell**
 Address **1900 Cutaw Place**

19. **may 25 48** **C. W. Hedrick**
 (Data rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **May 23 1948** at **5:00 P.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **Feb 29 1948** to **May 23 1948** and that I last saw him alive on **May 23 1948**

Immediate cause of death **Cerebral hemorrhage** DURATION **Two hours**

Due to **Cerebral arteriosclerosis** **Shunt gas**

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? **Cundry**

23. SIGNATURE **Emo P. Gandy M.D.**
 Address **Relay 20, Md.** Date signed **5/23/48**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0473038

1. PLACE OF DEATH:

County BaltimoreCity or town Towson 4, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Since May 10, 1948Hospital, institution, or street address where death occurred:
Eudowood Sanatorium, Towson 4, Md.How long in hospital or institution? Since May 10, 1948

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore CityCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 578 S. Bond
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Alice Mae Lewis

3. (b) Social Security Number

4. Sex Female5. Color of race White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Gordon Lewis7. Birth date of deceased (mo., day, yr.) April 11, 19016. (c) If alive, give age 47 years8. AGE: Years 47 Months 1 Days If less than one dayhrs. min. 9. Birthplace Maryland
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Eugene Ford13. Birthplace Maryland14. Maiden name Thomas L. Key15. Birthplace Maryland16. Informant Personal history-Hospital recordsAddress Eudowood Sanatorium, Towson 4, Md.17. Burial Date thereof June 30, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory St. Andrews Bern.Location Princess Anne Co. Md.18. Funeral director Charles DashiellAddress Princess Anne Co. Md.19. 6/1 1948 AW Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 19 48 at 8:25 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 10 19 48, to May 30 19 48and that I last saw him alive on May 30 19 48Immediate cause of death Pulmonary tuberculosis

DURATION

SinceDec1942

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W.A. Bridges

M. D. or other

Address Towson 4, Maryland Date signed 5-30-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: *Balto.*
County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
2203 Alletta Ave
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State.....*Md*..... County.....*Balto.*
City or town.....*Lansdowne*
(If outside city or town limits, write RURAL and give nearest town)
Street No.....*2203 Alletta Ave*
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME
Maggie J. Little

3. (b) Social Security Number

4. Sex.....*Female*..... 5. Color or race.....*White*..... 6. (c) Single, married, widowed, or divorced.....*Widowed*
6. (b) Name of husband or wife.....*William Little*
7. Birth date of deceased (mo., day, yr.).....*Mar 27th 1869*
8. AGE: Years.....*79*..... Months.....*1*..... Days.....*23*..... hrs. min.

9. Birthplace.....*Balto. Md.*
(Town, county, and state)
10. Usual occupation.....*Housewife*
11. Industry or business.....*At Home*
12. Name.....*V. Emory High*
13. Birthplace.....*Balto. Md.*
14. Maiden name.....*Margaret A. Banko*
15. Birthplace.....*Balto. Md.*

16. Informant.....*Emory N. Kohlhaus*
Address.....*2203 Alletta Ave - Lansdowne*
17. Burial, cremation, or removal, Which?.....*Burial*..... Date thereof.....*5/24/48*
(month) (day) (year)
Cemetery or crematory.....*London Park*
Location.....*Balto. Md.*

18. Funeral director.....*William Cook Inc.*
Address.....*1217 St. Paul St.*

19. *May 24 1948* of *A. W. Hedgcock*
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....*May 20th 1948* at *10⁵⁵* P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Sept 28* 19*42* to *May 20* 19*48*
and that I last saw h. *ex* alive on *May 19* 19*48*
Immediate cause of death.....*Arteriosclerosis*

Due to.....*Coronary Vascular Disease with Hypertension*
Due to.....*6 years*

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings of operations.....
Date of op.....
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur?.....
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?).....
Means of injury..... Injured at work?

23. SIGNATURE.....*Eliot W. Johnson MD*
Address.....*3432 Frederick Ave*
Date signed.....*5/21/48*

MARGIN RESERVED FOR BINDING

9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians; please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

04732

44

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hospital, Ft. Howard, Md.How long in hospital or institution? 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 75 E. Fayette St.
(If rural, give LOCATION)2. (a) If veteran, name war WW-I

3. (a) FULL NAME

HARRY T. LIVENGOOD

3. (b) Social Security Number

Unknown

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widower6. (b) Name of husband or wife Widower7. Birth date of deceased (mo., day, yr.) 7-10-1892

6. (c) If alive, give age years

8. AGE: Years 55 Months 10 Days 17
If less than one day hrs. min.9. Birthplace Gilford Co., N.C.
(Town, county, and state)10. Usual occupation Unemployed

11. Industry or business

12. Name Louis Livengood13. Birthplace North Carolina14. Maiden name Mary White15. Birthplace North Carolina16. Informant Clinical Records, Vets. Adm. HospitalAddress Ft. Howard, Maryland.17. Burial Date thereof 6/2/48
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Baltimore National Cemetery
5501 Frederick Ave. Balto. Md.

Location

18. Funeral director William CookAddress St. Paul & Preston Sts. Balto. Md.19. 6/1 48 RW/Kedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 19 48 at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 25 19 48 to May 27 19 48and that I last saw him alive on May 27 19 48Immediate cause of death Chr. glomerulo-nephritis DURATION 10 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William H. Shackett M. D. or otherAddress VAH FT. Howard, Md. Date signed 5-29-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH: **Baltimore**
 County.....
 City or town.....**Catonsville**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....**29 days**
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution?.....**29 days**

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....**Maryland** County.....
 City or town.....**Baltimore-29**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....**3447 Old Frederick Road**
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....**No** ✓

3. (a) FULL NAME ~~Rebecca Lohr~~ **REBECCA H. LOHR** 3. (b) Social Security Number **No**

4. Sex **female** 5. Color or race **white** 6. (a) Single, married, widowed, or divorced **married**

6. (b) Name of husband or wife.....**Andrew Lohr**

7. Birth date of deceased (mo., day, yr.).....**September 19, 1877** 6. (c) If alive, give age.....**65** years

8. AGE: Years Months Days If less than one day
70 8 8hrs.min.

9. Birthplace.....**Baltimore, Maryland**
 (Town, county, and state)

10. Usual occupation.....**Housewife**

11. Industry or business.....**Home**

12. Name.....**Charles Ingram**

13. Birthplace.....**Virginia**

14. Maiden name.....**?**

15. Birthplace.....**Virginia**

16. Informant.....~~Hospital records~~ **MR. ANDREW LOHR**

Address.....~~Catonsville-28, Maryland~~ **3447 Old Frederick Rd**

17. **BURIAL** Date thereof.....**5/21/48**
 (Burial, cremation, or removal. Which?)

Cemetery or crematory.....**LODON PARK**

Location.....**BALTO. MD.**

18. Funeral director.....**Wm. T. Tietmeyer & Sons**

Address.....**BALTO. MD.**

19. **5/29** 19. **48** **RA. Reduch**
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....**May 27** 19. **48** at **5:20 p.m.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **April 28** 19. **48**, to **May 27** 19. **48** and that I last saw him/her alive on **May** 19. **48**

Immediate cause of death.....**Bilateral lobar pneumonia (terminal)** DURATION **60 hrs.**

Adenomatous goitre with cystic

Due to.....**changes** indefinite

Glomerular nephritis (3rd stage) "

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....**as above**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

Signature.....**Isadore Tuerk, M.D.**

Address.....**Catonsville-28, Maryland** M. D. or other

Date signed.....**5-28-48**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County BaltimoreCity or town Baldwin
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 25

Hospital, institution, or street address where death occurred:

How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County HarfordCity or town Baldwin
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Laura Luvenia Loker

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

Wm A Loker

7. Birth date of deceased (mo., day, yr.)

Aug 14 1866

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

81827

hrs.

min.

9. Birthplace

Forest Hill

(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

MOTHER FATHER

12. Name

John Deubow

13. Birthplace

May Elizabeth Scott

14. Maiden name

Harford Co md.

15. Birthplace

16. Informant

Mrs Wm Francis

Address

Baldwin md.

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

May 10 1948
(month) (day) (year)

Cemetery or crematory

Friendship

Location

Fallston Harford Co md

18. Funeral director

Wm E. Smith

Address

Janettsville md.

19.

May 10 1948C. E. Arthur
D. 2012 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8, 1948 at 1:55 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 6, 1938 to May 8, 1948and that I last saw him alive on May 8, 1948

Immediate cause of death

Cerebral Hemorrhage

DURATION

4 hrs.HypertensiveCardiovascular Disease10 yrs.

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

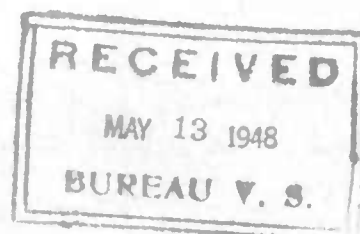
Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

Clifford F. Hudson, M.D.
M. D. or other _____Address Fork, md. Date signed 5/8/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

04734

CERTIFICATE OF DEATH

Reg. Dist. No. ... 31

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
(For newborn infants give residence of mother)			
County <u>Baltimore</u>		State <u>Maryland</u> County <u>Baltimore</u>	
City or town <u>Randallstown</u>		City or town <u>Randallstown</u>	
(If outside city or town limits, write RURAL and give nearest town)		(If outside city or town limits, write RURAL and give nearest town)	
How long in above place of death? <u>9 weeks</u>		Street No. <u>Wilbur Ave</u>	
Hospital, institution, or street address where death occurred:		(If rural, give LOCATION)	
How long in hospital or institution? _____		2.(a) If veteran, namn war _____	
3. (a) FULL NAME <u>Jacob Phillip Luers</u>		3. (b) Social Security Number _____	
MEDICAL CERTIFICATION			
4. Sex <u>Male</u>		20. DATE OF DEATH <u>May 14 - 1948</u>	
5. Color or race <u>White</u>		21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>Feb. 1st 1948</u> to <u>May 14 1948</u>	
6. (a) Single, married, widowed, or divorced <u>Married</u>		and that I last saw him alive on <u>May 14, 1948</u>	
B. (b) Name of husband or wife <u>Elizabeth S. Luers</u>		Immediate cause of death <u>Coronary Occlusion</u>	
7. Birth date of deceased (mo., day, yr.) <u>12/15/1871</u>		DURATION	
8. AGE: Years <u>76</u> Months <u>4</u> Days <u>29</u>		Due to <u>Cardiovascular Disease</u>	
If less than one day _____ hrs. _____ min.		Due to _____	
9. Birthplace <u>Baltimore</u>		Other conditions _____	
(Town, county, and state)		(Include pregnancy within 3 months of death)	
10. Usual occupation <u>Farmer</u>		Major findings of operations _____	
11. Industry or business _____		Dain of op. _____	
12. Name <u>Peter Bernard Luers</u>		Autopsy results _____	
13. Birthplace <u>Germany</u>		PHYSICIAN: Please underline the cause to which death should be charged statistically.	
14. Maiden name <u>Catharina Schultz</u>		22. VIOLENCE: If death was due to external causes, fill in the following:	
15. Birthplace <u>Germany</u>		Accident, suicide, or homicide _____ Date of _____	
16. Informant <u>Joseph Luers</u>		Where did injury occur? _____	
Address <u>Wilbur Ave. Randallstown</u>		(City or town) _____ (County) _____ (State) _____	
17. <u>Burial</u> Date thereof <u>May 17-48</u>		Injured at home, farm, industry, public place (where?) _____	
(Burial, cremation, or removal, Which?) _____ (month) (day) (year)		Means of injury _____ Injured at work? _____	
Cemetery or crematory <u>Holy Family</u>		23. SIGNATURE <u>For. E. Martin</u>	
Location <u>Harrisonville, Md</u>		M. D. or other _____	
18. Funeral director <u>Frank H. Newell</u>		Address <u>Randallstown, Md</u>	
Address <u>Pikesville, Md</u>		Date signed <u>5/16/48</u>	
19. <u>5/15/1948</u> <u>For. E. Martin</u>			
(Date rec'd by registrar)		Registrar	

OFFICE OF THE ATTORNEY GENERAL

STATE OF NEW YORK

RECEIVED
MAY 20 1948
BUREAU V. S.

CERTIFICATE OF DEATH

Registered No. 486

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland BALTIMORE COUNTY
 (b) Street address 5313 Edmondson Ave.
 (c) Hospital or institution: Hood Nursing Home
 (d) Length of stay in hospital or inst. (yrs., mos., or days) _____
 (e) Length of stay in Baltimore (yrs., mos., or days) _____

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County _____
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 1236 Hull St.
 (If rural give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3 (a) FULL NAME

Lillian Lesniewski Majewski

3 (b) If veteran, name war _____

3 (c) Social Security Account No. _____

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

Female White

Married

6 (b) Name of husband or wife

Joseph

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

Dec. 8 1898

8. AGE: Years

Months

Days

If less than one day

49

____ hr. ____ min.

9. Birthplace

Poland

(Town, county, and state)

10. Usual Occupation

House Wife

11. Industry or business _____

FATHER

12. Name J. Fronczkowski

13. Birthplace

Poland

MOTHER

14. Maiden Name

Unk.

15. Birthplace

Poland

16 (a) Informant Joseph Majewski

(b) Address

1236 Hull St.

17 (a) Burial

(b) Date thereof June 2/48

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Holy Rosary

Location

Baltimore

18 (a) Funeral director

Prod W O Zagorski

(b) Address

1930 Eastern Ave.

19 (a) 6/1/48

(b)

A W Delich

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1948, at 8:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 28 May 1948 to 29 May 1948 and that I last saw her alive on 29 May 1948.

Immediate cause of death

Cerebral infarction

Duration

8 months

Due to _____

Due to _____

Other Conditions _____

(Include pregnancy within 3 months of death)

Date of operation _____

Major findings of operation: _____

of autopsy: _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide _____
 (b) Date of occurrence _____ at _____ M
 (c) Where did injury occur? _____
 (City or town) (County) (State)
 (d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____
 (Specify type of place)

(e) Means of injury _____

23. Signature

John A. Herbst

Address 207 E. Preston St.

Date signed June 4, 1948

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE

cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04736

Reg. Dist. No. 40

1. PLACE OF DEATH:

County... Baltimore
 City or town... Perry Hall, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 20 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State... Maryland County... Baltimore
 City or town... Perry Hall, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... Belair Rd.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

DAVID F. MAY

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced widower
 6.(b) Name of husband or wife Mary May
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Aug. 30th, 1863
 8. AGE: Years 84 Months 8 Days 3 It less than one day _____ hrs. _____ min.
 9. Birthplace Virginia
 (Town, county, and state)
at home
 10. Usual occupation _____
 11. Industry or business _____

FATHER
MOTHER

12. Name Silas May
 13. Birthplace Virginia
 14. Maiden name Mary Souder
 15. Birthplace Virginia

16. Informant Mr. August R. Schroeder
 Address Belair Rd., Fullerton P.O.

17. burial Date thereof 5/6/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory St. Michaels Lutheran
Perry Hall, Md.
 Location _____

18. Funeral director Lassahn Funeral Home
 Address 7401 Belair Rd.

19. 5/7/48 19. W. M. [Signature]
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3rd, 19 48 at 1 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 8th 19 47 to May 3rd 19 48
 and that I last saw him alive on May 2nd 19 48

Immediate cause of death _____ DURATION
Myocardial Infarction 4 days
 Due to Cerebral Hemorrhage 4 days
 Due to Arterio-Sclerosis 5 yrs
 Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

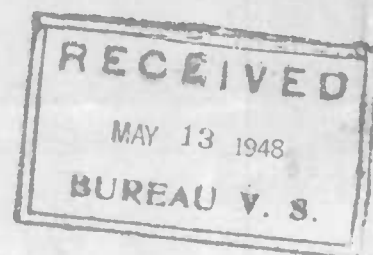
22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State) _____
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE S. E. [Signature] M. D. or other
 Address 100 [Signature] Date signed 5/3/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The doctor's age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

MAY 13 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Baltimore
City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 Days
Hospital, institution, or street address where death occurred:
Vets. Adm. Hospital, Ft. Howard, Md.
How long in hospital or institution? 25 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Kentucky County
City or town West Liberty
(If outside city or town limits, write RURAL and give nearest town)
Street No. See above.
(If rural, give LOCATION)
2.(a) If veteran, name war VV-I ✓

3. (a) FULL NAME

GUS McCLEES

3. (b) Social Security Number

Unknown

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of spouse or wife Dora McClees
6. (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) 2-5-95

8. AGE: Years 53 Months 3 Days 10 It less than one day hr. min.

9. Birthplace Rowan County, Ky.
(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

FATHER 12. Name Isaac McClees
13. Birthplace Ohio

MOTHER 14. Maiden name Mary McGinity
15. Birthplace Kentucky

16. Informant Clinical Records, Vets. Adm. Hosp.
Ft. Howard, Maryland

17. Removal Date thereof May 15, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Combs Cemetery

Location Johnson's Funeral Home, Hazard, Ky.

18. Funeral director Howard N. Blight
Address Belair Rd, Baltimore, Md.

19. May 17 19 48 W. A. H. Parker
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14, 19 48 at 6:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 20, 19 48 to May 14, 19 48
and that I last saw him alive on May 14, 19 48

Immediate cause of death Meningitis DURATION 12 Days

Due to Bacillus Pyocyaneus " "

Other conditions Carcinoma, squamous cell, 11 Mos.
scalp with metastases to brain
(Include pregnancy within 3 months of death)

Major findings of operations Debridement of scalp, frontal bone, and dura right Date of op. 4-29-48

Autopsy results No Autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Robert Larnier M. D. or other
R. L. LARNER, M. D.
Address V. A. H. Ft. Howard, M. D. Date signed 5-15-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 19 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

04738

44

1. PLACE OF DEATH:

County..... BaltimoreCity or town..... Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Vets. Adm. Hospital, Ft. Howard, Maryland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....City or town..... Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 1572 Aliceann Street
(If rural, give LOCATION)2.(a) If veteran, name war..... WW-I

3. (a) FULL NAME

JAMES McDERMOTT

3. (b) Social Security Number

Unknown

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Unknown6.(b) Name of husband or wife..... Unknown

7. Birth date of deceased (mo., day, yr.)

2-14-93

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

55310

hrs.

min.

9. Birthplace..... Scotland

(Town, county, and state)

10. Usual occupation..... Unknown

11. Industry or business

MOTHER FATHER

12. Name..... Unknown13. Birthplace..... "14. Maiden name..... "

15. Birthplace

16. Informant..... Clinical Records, Vets. Adm. HospitalAddress..... Ft. Howard, Maryland17. Burial
(Burial, cremation, or removal. Which?)Date thereof..... 5/26/48
(month) (day) (year)Cemetery or crematory..... Baltimore National CemeteryBaltimore, Maryland

Location

18. Funeral director..... Howard BlightAddress..... 4914 Belair Rd., Baltimore, Md.19. May 25 48
(Date rec'd by Registrar)A. W. H. Davis
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 24, 1948 at 2:40 A.M.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from
May 23, 1948 to May 24, 1948
and that I last saw him alive on May 24, 1948

Immediate cause of death

Extensive fibrocaceous tuberculosis

DURATION

unknown

Due to.....

Due to.....

Other conditions..... Coronary Occlusion

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results..... Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE

M. B. Davis
Apr. 25 48 Date signed.....
A. W. H. Davis Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04738

1. PLACE OF DEATH: **Baltimore**

Cocooy.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....
 Hospital, institution, or street address where death occurred:
1612 Yakona Rd.

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
2610 Gwynndale Ave.
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Oscar Leonard McKenny

3. (b) Social Security Number

4. Sex **Male** 5. Color or race **W.** 6.(a) Single, married, widowed, or divorced **Married**

6.(b) Name of husband or wife **Ruth V. (nee Brittingham)**

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) **Jan. 26, 1892.**

8. AGE: Years **56** Months **3** Days **25** If less than one day
 hrs. min.

9. Birthplace **Balto. Md.**
 (Town, county, and state)

10. Usual occupation **Butcher**
 11. Industry or business **American Stores**

12. Name **William McKenny**13. Birthplace **Md.**14. Maiden name **Unknown**15. Birthplace **Unknown**

16. Informant **Mrs. Ruth. V. McKenny.**
 Address **2610 Gwynndale Ave.**

17. Burial Date thereof **May 25/48.**
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory **Woodlawn**Location **Woodlawn, Md.**

18. Funeral director **Harry N. Winkler**
 Address **4101 Edmondson Ave.**

19. **may 24, 1948** **A. W. Hester**
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **May 21/48.** 19..... at **1 08** M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **July** 19..... to **21 May** 19.....
 and that I last saw him/her on **21 May** 19.....

Immediate cause of death.....
arterio-sclerotic Cardiac
Vascular Disease

DURATION

6 yrs.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE.....

M. D. or other

Address **6201 York Rd** Date signed **21 May 48**

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 192

1. PLACE OF DEATH:

County BALTIMORE

City or town WOODSTOCK MD
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BALTO

City or town WOODSTOCK COLLEGE
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

BROTHER JOHN MC MULLEN

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

MALE WHITE SINGLE

6.(b) Name of husband or wife _____

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) JUNE 29 - 1876

8. AGE: Years Months Days If less than one day
71 10 13 _____ hrs. _____ min.

9. Birthplace IRELAND.
(Town, county, and state)

10. Usual occupation RELIGIOUS

11. Industry or business ENGINEER

12. Name NOT KNOWN

13. Birthplace "

14. Maiden name "

15. Birthplace "

16. Informant REV JOS BKURT SJ

Address WOODSTOCK COLLEGE

17. BURIAL Date thereof MAY 19 - 48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory WOODSTOCK COLLEGE CEM

Location WOODSTOCK MD

18. Funeral director Bernard E. Harle

Address 121 E West St Balto 30 MD

19. 512 YE A.W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY - 16 19 48 at 5:45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 48 to May 16 19 48 and that I last saw him alive on May 16 19 48

Immediate cause of death myeloid leukemia DURATION _____

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results X

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Harold H Burns M. D. or other _____

Address 529 N Charles St Date signed May 17, 48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0474138

1. PLACE OF DEATH

County Baltimore
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? About 5 wks
 Hospital, institution, or street address where death occurred:
Box 49, Pransden Rd.; (Hawson 4)
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2619 N. Calvert St.
 (If rural, give LOCATION)
 2.(a) Is veteran, name war _____

3. (a) FULL NAME

Louise B. McNamee

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Francis J. McNamee
 6. (c) If alive, give age 63 years
 7. Birth date of deceased (mo., day, yr.) March 11, 1880
 8. AGE: Years 68 Months 2 Days 18 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Md.
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business _____

MOTHER FATHER
 12. Name William Bolander
 13. Birthplace Germany
 14. Maiden name Fredenicka Gross
 15. Birthplace Germany
 16. Informant Francis J. McNamee (husband)
 Address 2619 N. Calvert St. Balto. 18, Md
 17. Burial Date thereof June 1, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Baltimore Cemetery
 Location Baltimore, Md.
 18. Funeral director P. Howard Evans
 Address 1800 S. Charles St. Balto. 30 40
 19. 6/1 48 AW Hedlund
 (Date rec'd by registrar) (year) (month) (day) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sat. May 29, 1948 at 9:30 P.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MARCH - 12, 1947 to MAY - 29, 1948
 and that I last saw him alive on MAY - 29 - 1948
 Immediate cause of death CEREBRAL HEMORRHAGE DURATION 3 DAYS
 Due to HYPERTENSION 8 YRS.
 Due to ARTERIO-SCLEROSIS 10 YRS.
 Other conditions _____
ARTERIO-SCLEROTIC HEART DISEASE
 (Include pregnancy within 3 months of death)
 Major findings of operations NONE Date of op. _____
 Autopsy results NONE
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE Stuart D. Sunday M. D. or other _____
 Address 201 E. 33rd St. Date signed MAY - 29 - 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

04742 32

1. PLACE OF DEATH:

County Baltimore
City or town Brooklandville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 years
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Baltimore
City or town Brooklandville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Lutherville P.O.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Laura Ellen Mealey

3. (b) Social Security Number

4. Sex F. 5. Color or race W 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Wm A. Mealey

7. Birth date of deceased (mo., day, yr.) Nov. 19, 1856 6.(c) If alive, give age _____ years

8. AGE: Years 91 Months 5 Days 18 If less than one day _____ hrs. _____ min.

9. Birthplace Va.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

12. Name Baldwin Harris

13. Birthplace Va.

14. Maiden name Lizzie Lawrence

15. Birthplace Va.

16. Informant Charles N. Mealey

Address Lutherville, Md

17. Burial Date thereof May 10, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Springfield Cemetery

Location Lutherville, Md

18. Funeral director C. Harry Wood

Address Lutherville, Md

19. 5-8-48 Dr E E Nichols
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1948 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Several years 1919 to May 7 1948
and that I last saw him alive on May 6 1948

Immediate cause of death Arterio-sclerosis

Due to _____

Due to _____

Other conditions Senility

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE E. E. Nichols M. D. or other

Address Lutherville Md Date signed 5-8-48

MARGIN RESERVED FOR BINDING

VS 415 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

115

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MAY 11 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Baltimore
City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 Days
Hospital, institution, or street address where death occurred:
Vets. Adm. Hospital, Ft. Howard, Maryland
How long in hospital or institution? 11 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____
City or town 515 Willow Avenue
(If outside city or town limits, write RURAL and give nearest town)
Street No. Baltimore, Maryland (15)
(If rural, give LOCATION)
2.(a) If veteran, name war SAW

3. (a) FULL NAME

ROBERT W. MESSENGER

3. (b) Social Security Number

223-18-1906

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Anna Z. Messenger
6.(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) 2-23-1870

8. AGE: Years 78 Months 2 Days 15 It less than one day _____ hrs. _____ min.

9. Birthplace Peru, Mass.
(Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business _____

12. Name Henry Messenger

13. Birthplace Mass.

14. Maiden name Eliza Frizzell

15. Birthplace Mass.

16. Informant Clinical Records, Vets. Adm. Hosp.
Address Fort Howard, Maryland

17. Burial Date thereof May 11 48
(Burial, cremation, or removal. Which?) (Month) (day) (year)

Cemetery or crematory Federal Cemetery

Location Federalburg, Md.

18. Funeral director J.J. Frampton

Address Federalburg, Md.

19. May 8 - 48 Registrar Dawson L. Harber

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8, 19 48 at 7:55 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 27, 19 48, to May 8, 19 48

and that I last saw him alive on May 8, 19 48

Immediate cause of death Thrombosis left coronary artery DURATION 2 weeks

Due to Arteriosclerosis plus

Due to _____ Unknown

Other conditions (1) mural thrombosis, left 2 weeks

ventricle, cause myocardial in- plus

farction. (2) Splenic infarction due to (1) duration, unknown

Major findings of operations _____ Date of op. _____

Autopsy results Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Milton Ginsberg

MILTON GINSBERG, M. D. M. D. or other _____

Address V.A.H. FORT HOWARD, MD. Date signed 5-8-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 11 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04744

Reg. Dist. No. 30

1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 11 days

Hospital, institution, or street address where death occurred:

Spring Grove State HospitalHow long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Balt., CityCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 2520 Greenmount Ave

(If rural, give LOCATION)

2.(a) If veteran, name war -

3. (a) FULL NAME

Charles Miller

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Mary Nelson7. Birth date of deceased (mo., day, yr.) September 22, 1862

6. (c) If alive, give age (d) years

8. AGE: Years Months Days It less than one day
85 8 7 hrs. min.9. Birthplace Germany
(Town, county, and state)10. Usual occupation Glazer11. Industry or business -12. Name Carl Gottlieb Mueller13. Birthplace Germany14. Maiden name Caroline Ringel15. Birthplace Germany16. Informant Dr. BrunAddress 827 Park Avenue17. Burial Date thereof June 1, 48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Linden ParkLocation 3801 Frederick Ave18. Funeral director John O. Mitchell & SonsAddress 1900 Centaur Place19. 6/1 X AW Hedrick
(Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 19 48 at 8:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 18 19 48 to May 29 19 48and that I last saw him alive on May 29 19 48

Immediate cause of death

Arteriosclerotic Heart Disease DURATION yrsDue to Generalized Arteriosclerosis yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Isadore TuerkSpring Grove State Hosp. M. D. May 29/48

Address Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

04745

44

1. PLACE OF DEATH:

County Balto.
City or town Sparrow Pk.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Ship yard (S. Cubore)
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md. County Balto.
City or town Fallston Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Robert D. Mills

3. (b) Social Security Number

4. Sex M. 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Mary Ellen Mills
6. (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) Feb. 14 - 1910

8. AGE: Years 38 Months 3 Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Cowen - W. Va.
(Town, county, and state)

10. Usual occupation Elc. Welder

11. Industry or business Sparrow Point - Md

12. Name Robert D. Mills

13. Birthplace M. Va.

14. Maiden name Chloe Harrison

15. Birthplace W. Va.

16. Informant Mrs. Mary E. Carter

Address Fallston

17. Burial Date thereof May 15th 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory First Christian Church

Location Belair, Md.

18. Funeral director W. H. Archer

Address Benson Md.

19. May 13 - 48 Darwin L. Harber
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13, 1948 at 12:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____, 10____, 19____
and that I last saw him _____ alive on _____ 19____

Immediate cause of death Skull fracture (frontal)
Crushed

Due to Compound fracture upper

Due to 3rd rib fracture

Other conditions Fracture & dislocation
of humerus (fell 65 ft)

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 5/13/48

Where did injury occur? Sparrow Pk. Balto. (City or town) (State) Md.

Injured at home, farm, industry, or public place (where?) Best Steel Ship

Means of injury Fell from hold Injured by yes

23. SIGNATURE Dr. Harrison M.D.

Deputy Registrar Dr. Harrison Date signed 5/13/48
Address Balto Co. Dundalk Date signed _____

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr Farber
D St -

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MAY 15 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PC 138 04746 2 38 MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 2 38

1. PLACE OF DEATH:

County Baltimore
City or town Towson 4, Maryland
(if outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since July 10, 1947
Hospital, institution, or street address where death occurred:
Eudowood Sanatorium, Towson 4, Md.
How long in hospital or institution? Since 1947

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants, give residence of mother)

State Maryland County Balto City
City or town Baltimore
(if outside city or town limits, write RURAL and give nearest town)
Street No. 310 N Green St
(If rural, give LOCATION)
2. (a) If veteran, name war ✓

3. (a) FULL NAME

Albert Mason

3. (b) Social Security Number

228-16-1018

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married
6. (b) Name of husband or wife Jennie Mason
7. Birth date of deceased (mo., day, yr.) Feb 18, 1905 6. (c) If alive, give age 36 years
8. AGE: Years 43 Months 3 Days ✓ If less than one day hrs. min.

9. Birthplace Richmond, Va
(Town, county, and state)
10. Usual occupation Ship fitter
11. Industry or business ✓
12. Name My Logis Mason
13. Birthplace Richmond, Va
14. Maiden name Betty James Davis
15. Birthplace Radford, Va

16. Informant Personal History-Hospital records
Address Eudowood Sanatorium, Towson 4, Md.
17. Burial Date thereof June 2, 1948
(Burial, cremation, or removal, which) (month) (day) (year)
Cemetery or crematory Springfield Hill
Location Richmond, Va
18. Funeral director W. H. Hatten Funeral Home
Address Richmond, Va
19. 5731 19 48 J. Donaldson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 19 48 at 6:10 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10, 1947 to May 31, 1948
and that I last saw him alive on May 30, 1948

Immediate cause of death Pulmonary tuberculosis DURATION 2 1/2 years
Due to ✓

Due to ✓
Other conditions ✓

(Include pregnancy within 3 months of death)
Major findings of operations ✓
Date of op. ✓

Autopsy results ✓
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ✓ Date of ✓
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, pub'c place (where?)
Means of injury Injured at work?

23. SIGNATURE W. A. Bridges M. D. co-signer
Address Towson 4, Md. Date signed 5-31-48

RECEIVED

JUN 4 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03637

Reg. Dist. No. 40

1. PLACE OF DEATH

County Balt Co
 City or town Bradshaw Md
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balt.
 City or town Bradshaw Md
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Kate S. Morse

3. (b) Social Security Number

XXXXXX

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

Nov. 20 - 1870

8. AGE:

775-hrs

min.

9. Birthplace

Benton New Hampshire
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

MOTHER FATHER

12. Name

Daniel Howe

13. Birthplace

New Hampshire

14. Maiden name

Susan Clough

15. Birthplace

New Hampshire

16. Informant

Bernard A. Smith

Address

Bradshaw Md.

17.

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

May 6 1948C. E. Arthur

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 5 1948 at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 15 1948 to May 5 1948
 and that I last saw her alive on May 5 1948

Immediate cause of death

coronary occlusion

DURATION

3 weeks

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

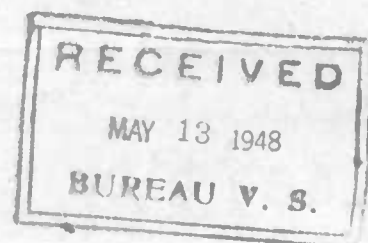
23. SIGNATURE

Red O Hodono, M.D.

M. D. or other

Address

Edgewood MdDate signed May 5 1948



RECEIVED

MAY 13 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03638

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County BALTO
City or town CATONSVILLE
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 MONTHS
Hospital, institution, or street address where death occurred:
19 Woodlawn Rd
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County
City or town CATONSVILLE
(If outside city or town limits, write RURAL and give nearest town)
Street No. 19 WOODLAWN RD.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

HATTIE HUTCHISON MOSS

3. (b) Social Security Number

No

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced WIDOWED
6. (b) Name of husband or wife WILLIAMSON WARE
7. Birth date of deceased (mo., day, yr.) SEPT. 16, 1881
8. AGE: Years 66 Months 8 Days 7 If less than one day
.....hrs.min.

9. Birthplace CONCORD, N.C.
(Town, county, and state)
10. Usual occupation HOUSEWIFE
11. Industry or business

12. Name JOHN S. HUTCHINSON
13. Birthplace N.C.

14. Maiden name MATTIE MCNINCH
15. Birthplace N.C.

16. Informant MR. WILLIAMSON W. MOSS JR.
Address 5715 MAIN ST. - ELKIDGE, MD

17. BURIAL Date thereof 5/26/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory LAPRAINE
Location BALTO Co., MD

18. Funeral director WM. T. TIGHER & SON
Address BALTO, MD

19. may 25 48 A. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/23/48 at 15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 15 1948 to May 23 1948
and that I last saw him alive on May 22 1948

Immediate cause of death

Coronary Thrombosis - 1 yr
Due to chronic myocarditis, general
Due to arteriosclerosis years
Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Shirley C. Blake
M. D. or other

Address Med. Arts Bldg Date signed 5-23-48

MARGIN RESERVED FOR BINDING

VS A1B 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 047432

1. PLACE OF DEATH:

County Baltimore
City or town Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 3 mos., 18 days
Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. T. B. Sanatorium
How long in hospital or institution? 1 yr., 3 mos., 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Talbot Co.
City or town Centreville Rd., Easton
(If outside city or town limits, write RURAL and give nearest town)
Street No. Centreville Road
(If rural, give LOCATION)
2.(a) If veteran, name war.

3. (a) FULL NAME

L. Mitchell Mullikin

3. (b) Social Security Number

Unknown

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Divorced

6. (b) Name of husband or wife Katie S. Mullikin
(Divorced)

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11, 1898

8. AGE:

Years

49

Months

11

Days

7

If less than one day

hrs. min.

9. Birthplace Easton, Maryland
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name Roland Mullikin

13. Birthplace Easton, Maryland

14. Maiden name Susanna Caulk

15. Birthplace Talbot Co., Maryland

16. Informant L. Mitchell Mullikin

Address Centreville Rd., Easton, Md.

17. Burial Date thereof 5/21/48
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Spring Hill

Location Easton, Maryland

18. Funeral director Ellis R. Clark

Address Easton, Maryland

19. May 18, 1948 Nela R. Nayer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18, 1948 at 7:12 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 31, 1947 to May 18, 1948

and that I last saw him alive on May 18, 1948

Immediate cause of death

Pulmonary Tuberculosis

DURATION

18

mos.

Due to Tubercle Bacilli

Due to

Other conditions Cardiac Asthma

Unknown

(Include pregnancy within 8 months of death)

Major findings of operations No operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

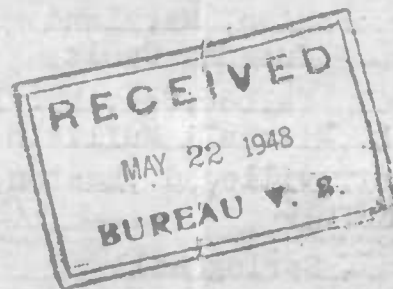
23. SIGNATURE Stewart S. Shaffer M.D.
M. D. or other

Address Mt. Wilson, Md. Date signed 5/18/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Frederick A. Murk4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Widower6. (b) Name of husband or wife Margaret A. Hartman

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) April 1, 18588. AGE: Years 90 Months 1 Days 22 If less than one day _____ hrs. _____ min.9. Birthplace Maryland
(Town, county, and state)10. Usual occupation Retired

11. Industry or business

12. Name John Murk13. Birthplace Germany14. Maiden name Unknown

15. Birthplace

16. Informant Mrs. John BooneAddress Ellicott City, Md.17. Burial Date thereof 5-25-48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. MarysLocation Ilchester Md.18. Funeral director F. C. HiginbothamAddress Ellicott City, Md.19. 5-24 19 48 VE Harry
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HowardCity or town Ellicott City
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (d) If veteran, name war _____

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 19 48 at 3 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10 19 48 to May 23 19 48and that I last saw him alive on May 22 19 48Immediate cause of death Coronary Thrombosis DURATION 3 daysDue to Arterio Sclerosis

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ injured at work? _____

23. SIGNATURE John Howard M. D. or other _____Address Catonsville Date signed 5/24

Mr. Maxwell

Arbitus 664

1014 Francis Ave.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

County Baltimore
City or town Owings Mills
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State MD County Baltimore
City or town Owings Mills
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Dr. Wilhelmsen Myers

3. (b) Social Security Number

4. Sex Male 5. Color of race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Edith

7. Birth date of deceased (mo., day, yr.) Apr. 17, 1883

8. AGE: Years 64 Months 5 Days 14 less than one day
hrs. min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual occupation Mechanic

11. Industry or business Gen. L. Motors

12. Name Wilhelmsen

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant Edith Myers

Address Owings Mills, Md.

(Burial, cremation, or removal, when?) Date thereof 5/4/48
(month) (day) (year)

Cemetery or crematory Grind Ridge

Location Elkridge, Md.

18. Funeral director William Cook, Inc.

Address 1217 1/2 Bond St.

19. May 3, 1948 A. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1, 1948 at 9:40 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1948 to 5-1-48 1948

and that I last saw him alive on 4-30-48 1948

Immediate cause of death Myocardial infarction

Due to Coronary artery disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James B. Saffell

M. D. or other

Address Reston, Va. Date signed 5/1/48

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 months, 4 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 7 months, 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1639 West North Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war ✓

3. (a) FULL NAME

Jessie M. Myers

3. (b) Social Security Number

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife — 6. (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1868 JUL 21

8. AGE: Years 79 Months 9 Days 14 (If less than one day) — hrs. — min.

9. Birthplace Balto.
 (Town, county, and state)

10. Usual occupation —

11. Industry or business —

12. Name James J. Myers

13. Birthplace Ind.

14. Maiden name Susie Jean Bowen

15. Birthplace Ind.

16. Informant Hospital records
 Address 1684 W. North Ave. Catonsville-28, Maryland

17. Buried Date thereof 8 May 48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematorium Armenian

Location Balto. Ind.

18. Funeral director Wm. J. Tiekner & Son

Address Balto. Ind.

19. May 7 1948 A. W. Hedrick
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 19 48 at 9:00 p. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1 19 47 to May 5 19 48
 and that I last saw her alive on May 5 19 48

Immediate cause of death Cardiac failure DURATION 3 hours

Arteriosclerosis, generalized indefinite
 Due to Arteriosclerotic heart disease "

Hypertensive cardiovascular
 disease "

Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury Isadore Turk Injured at work? —

23. SIGNATURE Isadore Turk, M.D. M. D. or other —

Address Catonsville-28, Maryland Date signed 5-6-48

CERTIFICATE OF DEATH

Registered No. *42*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: *Halethorpe*
 (a) Baltimore City, Maryland
 (b) Street address: *Washington Rd. & Reggs Ave*
 (c) Hospital or institution:
 (d) Length of stay in hospital or inst. (yrs., mos., or days)
 (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State: *Md* (b) County:
 (c) City or town: *Baltimore*
 (If outside city or town limits, write RURAL and give town)
 (d) Street No.: *230 S Oldham St.*
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country:

3 (a) FULL NAME: *John*
 3 (b) If veteran, name war: No. 3 (c) Social Security Account No.
 4. Sex: *Male* 5. Color or race: *White* 6 (a) Single, married, widowed, or divorced: *Married*
 6 (b) Name of husband or wife: *Mary F Neary*
 6 (c) If alive, give age *45* years
 7. Birth date of deceased (mo., day, yr.): *June 18, 1897*
 8. AGE: Years: *50* Months: Days: If less than one day: hr. min.

9. Birthplace: *Baltimore*
 (Town, county, and state)
 10. Usual Occupation: *Bethlehem Steel*
 11. Industry or business: *Metallurgical Dept*
 12. Name: *Thos Neary*
 13. Birthplace: *Ireland*
 14. Maiden Name: *Don't know*
 15. Birthplace: *Ireland*

16 (a) Informant: *Mr. Mary Neary*
 (b) Address: *230 S Oldham St*
 17 (a) *Burial* (b) Date thereof: *May 8, 1948*
 (Burial, cremation, or removal) (month) (day) (year)
 (c) Cemetery or crematory: *Cath. Lawn Cem*
 Location: *City*
 18 (a) Funeral director: *Lebrick Funeral Home*
 (b) Address: *2008 Orleans St*
 19 (a) *516148* *A. W. Hennes*

MEDICAL CERTIFICATION

20. DATE OF DEATH: *May 5, 1948*, at *1:20 PM*

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to *his* death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: *Fractured skull; Broken neck; Compound comminuted fracture of rt. leg bones; Fracture of left leg bones*

Other Conditions:
 (Include pregnancy within 9 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
 (a) Date of injury: *5-5-48* at *1:00 PM*
 (b) Where did injury occur? *Washington Rd & Reggs Ave*
 (c) Did injury occur at home, on farm, industrial place, in public place? *Public* While at work? *no*
 (d) Means of injury: *History of Hit & Run*
 23. Signature: *Harry J. Muller* M.D.
 Date signed: *5-5-48* Medical Examiner.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information fully, in correct age and legibly. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

518

BC

04752

30

Reg. Dist. No.

1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 months, 5 daysHospital, institution, or street address where death occurred:
Spring Grove State HospitalHow long in hospital or institution? 3 months, 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 3621 Oakmont Avenue, Pimlico
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Julius M. Newton

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

married6.(b) Name of husband or wife Anna Newton6.(c) If alive, give age 76 years7. Birth date of deceased (mo., day, yr.) April 21, 18718. AGE: Years Months Days If less than one day
77 1 5 hrs. min.9. Birthplace Morganton, North Carolina
(Town, county, and state)10. Usual occupation Cabinet Maker11. Industry or business Furniture12. Name Eli Newton13. Birthplace North Carolina14. Maiden name Dulcina White15. Birthplace North Carolina16. Informant Hospital recordsAddress Catonsville 28, Md.17. Burial Date thereof 5-28-48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematorium LorraineLocation Woodlawn Memorial18. Funeral director Loring BakerAddress 5005 Park Heights Ave.19. may 26 19 48 A. W. Tuerk
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26, 19 48 at 3:15 a.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
February 21, 19 48, to May 26, 19 48and that I last saw him alive on May 26, 19 48Immediate cause of death
Carcinoma of the prostate indefinite
Arteriosclerotic cardiovascular-
renal disease n

Due to

Due to

Other conditions Esophageal stenosis, stricture
at the level of cardia -suspect malignancy?
(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Isadore Tuerk, M.D.

M. D. or other

Address Catonsville 28, Md.Date signed 5/26/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County..... Baltimore
 City or town..... Fullerton, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 46 years
 Hospital, institution, or street address where death occurred:
Cowenton Ave.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Baltimore
 City or town..... Fullerton, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Cowenton Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

ANNA HARRISON NORRIS

3. (b) Social Security Number

4. Sex..... female 5. Color or race..... white 6.(a) Single, married, widowed, or divorced..... widowed
 6.(b) Name of husband or wife..... Ralph Wormeley Norris
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... August 25th, 1868
 8. AGE: Years..... 79 Months..... 9 Days..... 2 It less than one day..... hrs. min.

9. Birthplace..... West Virginia
 (Town, county, and state)
 10. Usual occupation..... at home

11. Industry or business

FATHER 12. Name..... William Harrison
 13. Birthplace..... West Virginia
 MOTHER 14. Maiden name..... Mary Bartlett
 15. Birthplace..... West Virginia

16. Informant..... Mrs. J. Frank Schmidt
 Address..... 5009 Embla Ave., Balto., 10, Md.

17. burial Date thereof..... 5/29/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Parkwood
 Location..... Baltimore, Md.

18. Funeral director..... Lassahn Funeral Home
 Address..... 7401 Belair Rd.

19. 0729rf 19. IT M Harrison
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 27 19..... 48, at..... 11:59 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 27 19..... 48 to..... May 27 19..... 48
 and that I last saw him alive on..... May 27 19..... 48

Immediate cause of death..... Coronary atherosclerosis DURATION.....

Due to..... arteriosclerosis

Due to.....

Other conditions..... Hypertensive cardiac-vascular disease
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

23. SIGNATURE..... F. W. Wehner, Jr., M.D.
 M. D. or other
 Address..... 1023 B Eastern Ave. Date signed..... May 27, 1948
Balto. 21, Md.

RECEIVED

JUN 7 1948

BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 04754 35

1. PLACE OF DEATH:

County Baltimore
City or town Heesford - Monkton P.O. (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 yrs.
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
City or town Heesford - Monkton P.O. - Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Big Rock Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3. (a) FULL NAME

Grace Irene Parkes

3. (b) Social Security Number

None

4. Sex Female 5. Color of race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife E. Seymour Parkes

6. (c) If alive, give age 66 years
7. Birth date of deceased (mo., day, yr.) Apr. 22, 1894

8. AGE: Year 54 Month 1 Day — It less than one day — hr. — min.

9. Birthplace Balto. Co., Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name George Muth
13. Birthplace Balto. Co., Md.

MOTHER 14. Maiden name Ada Gracey
15. Birthplace Balto. Co., Md.

16. Informant E. Seymour Parkes
Address Monkton, Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof May 24, 1948
(month) (day) (year)

Cemetery or crematory Geosops
Location Sparks, Md.

18. Funeral director London M. Brooks
Address Sparks, Md.

19. Date rec'd by registrar May 25 19 48 Registrar Mrs. H. M. Markline

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 19 48 at 11:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 48 to May 21 19 48
and that I last saw her alive on May 20 19 48

Immediate cause of death Pulmonary tuberculosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. M. France M. D. 5/21/48
Address Parkton, Md. Date signed

MARGIN RESERVED FOR BINDING

VS A15 9-43-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 28 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04755

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 days
 Hospital, institution, or street address where death occurred:
Vets. Adm. Hospital, Ft. Howard, Md.
 How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1550 Fremont Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war WW-I

3. (a) FULL NAME

JOHN H. PARKS

3. (b) Social Security Number

unknown

4. Sex Male 5. Color or race Negro 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Deceased
 7. Birth date of deceased (mo., day, yr.) December 3, 1890 6.(c) If alive, give age _____ years
 8. AGE: Years 57 Months 4 Days 28 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore County, Md.
 (Town, county, and state)
 10. Usual occupation Odd jobs
 11. Industry or business _____

12. Name John Parks
 13. Birthplace Baltimore Co., Md.
 14. Maiden name Celia Diamond
 15. Birthplace Baltimore Co., Md.

16. Informant Clinical Records, Vets. Adm. Hosp.
 Address Fort Howard, Maryland

17. Burial Date thereof 5-5-48
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Baltimore National Cemetery
 Location Baltimore, Maryland

18. Funeral director Charles R. Law
 Address 802 Madison Avenue, Balto., Md.

19. May 5 19 48 a. w. Hodges
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 19 48 at 3:00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 29 19 48 to May 1 19 48
 and that I last saw him alive on May 1 19 48

Immediate cause of death Syphilis of Aorta and Aortic Valve - Duration Unknown
 DURATION

Due to _____
 Due to _____

Other conditions Cardiac Dilatation & Hypertrophy due to above -
 (Include pregnancy within 3 months of death) Unknown

Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury V. F. Sciuillo Injured at work? _____

23. SIGNATURE V. F. Sciuillo, M.D. M. D. or other _____

Address VAH, Fort Howard, Md. Date signed _____

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:

County.....BALTO
City or town.....GRANITE
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

A LORENA PEACH.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....MD County.....BALTO
City or town.....GRANITE
(If outside city or town limits, write RURAL and give nearest town)
Street No.....ST PAUL AVE
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

4. Sex

FEM

5. Color or race

WHITE

6.(a) Single, married, widowed, or divorced

WIDOW

6.(b) Name of husband or wife.....CHARLES F PEACH.

7. Birth date of deceased (mo., day, yr.) SEPTEMBER 19-1885

6.(c) If alive, give age.....years

8. AGE: Years 67 Months 7 Days 18
hrs. min.9. Birthplace.....GRANITE MD
(Town, county, and state)

10. Usual occupation.....HOUSE WORK

11. Industry or business.....AT HOME

12. Name.....WILLIAM MILLER

13. Birthplace.....MARYLAND

14. Maiden name.....MARY BODKA.

15. Birthplace.....MARYLAND

16. Informant.....MISS THERESA PEACH.

Address.....GRANITE MD

17. BURIAL Date thereof MAY 11-1948
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory.....WOODLAWN CEM

Location.....WOODLAWN MD

18. Funeral director.....Bernard C. Harter

Address.....121 E. WEST ST

19. 7/5/48 Date recd by registrar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....MAY 7 1948, at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1944 to May 7, 1948

and that I last saw him alive on May 7, 1948

Immediate cause of death

Cor Pulmonale
Emphysema

DURATION

Due to.....

Due to.....

Other conditions

Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

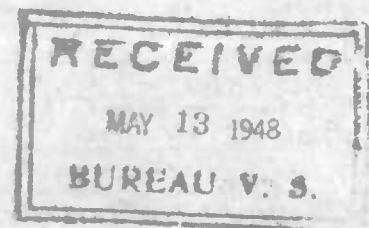
Means of injury

Injured at work?

23. SIGNATURE

Wm. E. Martin M. D. or other
Address.....Pawcatuck Date signed 5/8/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information fully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 186a 04757 30

1. PLACE OF DEATH:

County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Hood's Nursing Home, Edmondson Ave. & North Bend Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 123 Newburg Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Imogene Peirson

3. (b) Social Security Number

4. Sex Female 5. Color or race W. 6.(a) Single, married, widowed, or divorced Widow

6.(b) Name of husband or wife Late Harry W. Peirson

7. Birth date of deceased (mo., day, yr.) Oct. 31, 1862. 6.(c) If alive, give age years

8. AGE: Years 85 Months 6 Days 4 If less than one day hrs. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

MOTHER 12. Name Oursler
13. Birthplace Unknown

MOTHER 14. Maiden name Millicent Talbot
15. Birthplace Unknown

16. Informant Harry W. Peirson
Address 123 Newburg Ave.

17. Burial May 6/48
(Burial, cremation, or removal, Which?) Date thereof (month) (day) (year)
Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18. Funeral director Harry A. Witzke
Address 4101 Edmondson Ave.

19. May 5 19 48 a. w. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 19..... at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5 February 19 48 to 4 May 19 48
and that I last saw her alive on 26 April 19 48

Immediate cause of death Arteriosclerotic Hypertensive Cardiovascular disease DURATION over 5 years

Due to

Due to

Other conditions Fractured left hip in fall at home on 5 February 48 - plaster cast applied 3 months
(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide acc Date of 2/5/48

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of Injury fall Injured at work?

23. SIGNATURE John A. Hedrick Jr. M. D. or other

Address 20 E. Preston St - City Date signed 5 May 48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 238

04758

1. PLACE OF DEATH:

County Baltimore
 City or town Towson 4, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Since March 8, 1947
 Hospital, institution, or street address where death occurred:
Eudowood Sanatorium, Towson 4, Maryland
 How long in hospital or institution? Since March 5, 1947

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore City
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 3708 Glenmary Ave
 (If rural, give LOCATION)
 2. (a) If veteran, name war ✓

3. (a) FULL NAME

Harry Boston Perry

3. (b) Social Security Number

253-10-5447

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Sara O. Perry
 6. (c) If alive, give age 57 years
 7. Birth date of deceased (mo., day, yr.) July 23, 1884
 8. AGE: Years 63 Months 10 Days 8 If less than one day
 9. Birthplace London, England
 (Town, county, and state)
 10. Usual occupation Seafarer
 11. Industry or business Charles Perry
 12. Name Charles Perry
 13. Birthplace London, England
 14. Maiden name Lucia Boston
 15. Birthplace London, England

16. Informant Personal history- Hospital records
 Address Eudowood Sanatorium, Towson 4, Md.
 17. Burial Date thereof 6-3-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Parkwood
 Location Baltimore
 18. Funeral director Leonard J. Ryck
 Address 5305 Stanford Rd.
671 48 Dr. H. H. H. H.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 1948 at 1 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 5 1947 to May 31 1948
 and that I last saw him alive on May 31 1948
 Immediate cause of death Pulmonary tuberculosis
 Due to Since about March 1946
 Due to 1946
 Other conditions _____
 (Include pregnancy within 3 months of death)
 Major findings of operations _____
 Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE H. A. Bridges M. D. _____
 Address Towson 4, Md. Date signed 5-31-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH 468

Reg. Dist. No. 04759 42

1. PLACE OF DEATH:

County BALTO
City or town RELAY
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BALTO
City or town RELAY, MD.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5121 ROLLING RD - 27
(If rural, give LOCATION)
2.(a) If veteran, name war No

3. (a) FULL NAME

HOWARD LOVELL PFEIFFER

3. (b) Social Security Number

705-03-4167

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced M
6. (b) Name of husband or wife GERTRUDE A. PFEIFFER
6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) FEB. 5, 1883
8. AGE: Years 65 Months 3 Days 7 If less than one day _____ hrs. _____ min.

9. Birthplace ELK RIDGE, MD.
(Town, county, and state)
10. Usual occupation INSPECTOR OF ACCOUNTS
11. Industry or business T & O. R.R.
12. Name EDWARD PFEIFFER
13. Birthplace HOWARD Co. MD
14. Maiden name MINNIE EARP
15. Birthplace BALTO Co. MD

16. Informant GERTRUDE A. PFEIFFER (wife)
Address 5121 ROLLING RD
17. Burial Date thereof 5/13/48
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery LORRRAINE
Location BALTO Co. MD
18. Funeral director Wm J. Tietner & Son
Address BALTO, MD

19. May 3 1948 G. H. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/12 1948 at 2 35 PM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1942 to 5-12-1948
and that I last saw him alive on 5-11-1948

Immediate cause of death Carcinoma of prostate originating in pancreas
Due to Metastasis to liver
Due to _____

Other conditions Secondary anaemia
Coarctation
(Include pregnancy within 3 months of death)
Major findings of operations Carcinoma abdominal
origin not determined Date of op. _____
Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work?

23. SIGNATURE J. Edward. Becker M. D. or other
Address 723 Medical Arts Bldg. Date signed 5-13-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

04760

38

93d

1. PLACE OF DEATH:

County Baltimore
City or town Towson - Baynesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 weeks
Hospital, institution, or street address where death occurred
8502 Willow Oak Road
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Baynesville Towson PO
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8502 Willow Oak Road
(If rural, give LOCATION)
2.(a) If veteran, name war World War I

3. (a) FULL NAME

Constantine Gregory Polites

3. (b) Social Security Number

065-10-3261

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Amanda Chew Polites
6.(c) If alive, give age 49 years
7. Birth date of deceased (mo., day, yr.) June 14, 1897
8. AGE: Years 50 Months 10 Days 32 If less than one day — hrs. — min.

9. Birthplace Athens, Greece
(Town, county, and state)
10. Usual occupation Cafeteria Proprietor
11. Industry or business Self
FATHER 12. Name Gregory Polites
13. Birthplace Greece
MOTHER 14. Maiden name Unknown
15. Birthplace "

16. Informant Mrs. Amanda Polites
Address 8502 Willow Oak Rd, Towson, Md.
17. Burial Date thereof May 11, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Pleasantville Cemetery
Location Pleasantville, Atlantic Co., New Jersey
18. Funeral director John Burne' Sons
Address Towson, Maryland
19. May 8 19 48
(Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6, 1948 at 6 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from None 19 — to 19 —
and that I last saw h None alive on 19 —

Immediate cause of death Coronary Occlusion
Due to Heart Disease, myocarditis
Chronic
Due to —
Other conditions —
(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE Rollin C. Hudson MD. DME.
M. D. or other —
Address Towson 4, Md Date signed 5/6/48

MARGIN RESERVED FOR BINDING

VS A15 1-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 19 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04761
43

1. PLACE OF DEATH:

County..... Baltimore
 City or town..... Overlea, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 6 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Baltimore
 City or town..... Overlea, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 27 W. Elm Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

MILVIN R. POWERS

3. (b) Social Security Number

4. Sex..... female
 5. Color or race..... white
 6.(a) Single, married, widowed, or divorced..... married
 6.(b) Name of husband or wife..... Charles W. Powers
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... Dec. 6th, 1909
 8. AGE: Years..... 38 Months..... 4 Days..... 26 If less than one day..... hrs. min.

9. Birthplace..... Frederick County, Md.
 (Town, county, and state)
 10. Usual occupation..... at home

11. Industry or business

12. Name..... Melvin T. Tucker
 13. Birthplace..... Unknown
 14. Maiden name..... Anna M. Wise
 15. Birthplace..... Unknown

16. Informant..... Mr. Charles W. Powers
 Address..... 27 W. Elm Ave., Overlea, Md.

17. burial Date thereof..... 5/5/48
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory..... Parkwood
 Location..... Baltimore, Md.

18. Funeral director..... Lassala Funeral Home
 Address..... 7401 Belair Rd

19. 5/3/48 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 2nd 19..... 48 at 2:20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1st 19..... 47 to May 1st 19..... 48 and that I last saw him alive on April 1st 19..... 48
 Immediate cause of death.....
 DURATION

myocardial infarction
 Due to..... hypertension 1 yr.
 Due to..... chronic interstitial nephritis 2 yrs.
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury..... Injured at work?

SIGNATURE..... Edith A. Benson M. D. or other
 Address..... 1 W. Overlea Ave Date signed..... 5/3/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certifier's age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04762

31

Reg. Dist. No.

1. PLACE OF DEATH: Baltimore

County.....

City or town.....Woodlawn

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Maryland..... County.....BaltimoreCity or town.....Woodlawn

(If outside city or town limits, write RURAL and give nearest town)

Street No.....Johnnycake Road

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (a) FULL NAME

Charles A. Pratt

3. (b) Social Security Number

4. Sex..... <u>Male</u>	5. Color or race..... <u>White</u>	6. (a) Single, married, widowed, or divorced..... <u>Single</u>
-------------------------	------------------------------------	---

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....August, 11th., 1874

8. AGE: Years..... <u>73</u>	Months..... <u>9</u>	Days..... <u>19</u>	If less than one day.....hrs.min.
------------------------------	----------------------	---------------------	--

9. Birthplace.....Cambridge, Mass

(Town, county, and state)

10. Usual occupation.....Pharmist

11. Industry or business.....

12. Name.....Charles Warren Pratt13. Birthplace.....Cohasset, Mass14. Maiden name.....Emily Elizabeth15. Birthplace.....Harve De Grace, Md16. Informant.....Mrs. Irvin GardnerAddress.....12 Sheppard St. Chevy Chase Md.17. Burial.....BurialDate thereof.....June, 2nd 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....Woodlawn CemeteryLocation.....Woodlawn, Baltimore Co. Md18. Funeral director.....E. Ellis LamoreanAddress.....4510 Liberty Heights Ave. Balto. Md19. 6/1.....XF.....A.W. Hedrick

(Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....May, 31st......1948, 12-30^a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....

and that I last saw h.....alive on.....19.....

Immediate cause of death.....

DURATION

Due to.....Coronary Occlusion

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....Dr. M. Kieffer.....Dr. M. KiefferAddress.....1010 Lehigh Ave......1010 Lehigh Ave.Date signed.....May 31-48.....May 31-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04763

Reg. Dist. No. 48

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:

Veterans Administration HospitalHow long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 582 Baker Street
(If rural, give LOCATION)2. (a) If veteran, name war WW

3. (a) FULL NAME

RAYMOND H. PRICE

3. (b) Social Security Number

Unknown

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Single

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 1948 at 9:10 A. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 2 1948, to May 3 1948and that I last saw him alive on May 3 1948

Immediate cause of death

ARTERIOSCLEROTIC ATROPHY OF BRAIN

DURATION

1 yr.
plus

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Substantiated above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H.C. Managh
H.C. MANAUGH, M.D., CHIEF, PROFESSIONAL SERV.Address VAH, Ft. Howard, Md. Date signed 5/3/48

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13, 18908. AGE: Years 57 Months 10 Days 20 If less than one day
..... hrs. min.9. Birthplace Baltimore County, Md.
(Town, county, and state)10. Usual occupation Odd jobs

11. Industry or business

12. Name Henry Price
13. Birthplace Eastern Shore, Md.14. Maiden name Emma James15. Birthplace Maryland16. Informant Clinical Records, Vet. Adm. Hosp.
Address Fort Howard, Md.17. Burial Date thereof May 7-1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baltimore National CemeteryLocation Baltimore, Md.18. Funeral director Edward RinggoldAddress 1463 N. Carey St. Balto. Md.19. May 6 1948 R. W. Helms
(Date rec'd by registrar) Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville - 28, Maryland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

20 N. Symington Avenue
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Catonsville - 28
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 20 N. Symington Ave.
 (If rural, give LOCATION)

2.(c) If veteran, name war

3. (a) FULL NAME

Maathy N. Putens

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Howard Putens

7. Birth date of deceased (mo., day, yr.) August 5, 1914 8. (c) If alive, give age _____ years

8. AGE: Years 33 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Md.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name George Bauer

13. Birthplace Baltimore, Md.

14. Maiden name Theresa Hartman

15. Birthplace Baltimore, Md.

16. Informant Mr. Howard Putens

Address 20 Symington Avenue

17. Burial 5/8/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or place of interment Loudon Park Cemetery

Location 3801 Frederick Ave., Baltimore, Md.

Funeral director Schimunek Funeral Home, Inc.

Address 2601-3-5 E. Madison Street

19. 5/7 19. 48
 (Date rec'd by registrar)

Registrar H. H. H.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 19 48 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-4-48 to 5-4-48 and that I last saw him alive on Not seen since 1948

Immediate cause of death Illuminating Gas Poisoning DURATION 2 hrs (est)

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 5-4-48

Where did injury occur? Catonsville Balto Md
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) 20 N. Symington Ave.

Means of injury _____ Injured at work? No

23. SIGNATURE Dr. D. D. Egles Med. Exam.
 M. D. or other _____

Address Gentinstown Ind Date signed 5-4-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:

County Balto.City or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? all lifeHospital, institution, or street address where death occurred 7200 Duncleghen Cr.

How long in hospital or institution

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Same CountyCity or town Same
(If outside city or town limits, write RURAL and give nearest town)Street No. 7200 Duncleghen Cr.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Elmer Wayne Pyle

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Louise R.7. Birth date of deceased (mo., day, yr.) July 23/19158. AGE: Years 32 Months 11 Days 5 if less than one day
hrs. min.9. Birthplace Monaca, Pa.
(Town, county, and state)10. Usual occupation Asst. Salesman11. Industry or business Prudential Life Ins Co12. Name Elmer C. Pyle13. Birthplace Acme, Pa.14. Maiden name Ann Robinson15. Birthplace Fayette City, Pa.16. Informant Dr. Louise R. Pyle (wife)Address above17. Cremation Date thereof May 31, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Crematory crematory Loudon ParkLocation Frederick Ave.18. Funeral director Roland L. FisherAddress 2112 Dundalk Ave.19. May 30 19 48 William M. Beery Jr.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28, 1948 at 8:20 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death.....

Coronary accident. Immediate

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

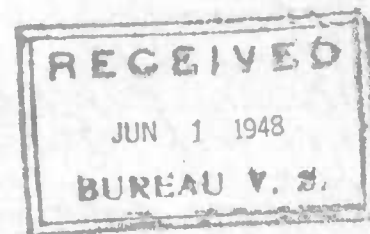
Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE William M. Beery Jr.Deputy RegistrarAddress Balto Co. Dundalk signed 5/28/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 31

1. PLACE OF DEATH:

County BaltimoreCity or town Bella Terra
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 year

Hospital, institution, or street address where death occurred:

Essex Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Bella Terra
(If outside city or town limits, write RURAL and give nearest town)Street No. Essex Road
(If rural, give LOCATION)2.(a) If veteran, name war 136. Madison : 1800 Bond St.

3. (a) FULL NAME

Catherine (Katie) Quirk

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

April ? 1871

8. AGE:

Years

Months

Days

If less than one day

.....hrs.min.

9. Birthplace

Maryland
(Town, county, and state)

10. Usual occupation

H/O

11. Industry or business

12. Name Patrick Quirk

13. Birthplace

Ireland

14. Maiden name

Margaret - Quirk

15. Birthplace

Ireland

18. Informant

Sadie French

Address

6300 Old Harford Road

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

5/31/48
(month) (day) (year)

Cemetery or crematory

Parkwood

Location

Baltimore

18. Funeral director

L. J. Quirk

Address

5385 Harford Road

19. 5/29/

(Date rec'd by registrar)

19. Wm E Martin
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29, 1948 10:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1946 to May 29, 1948and that I last saw her alive on May 28, 1948

Immediate cause of death

Chronic Valvular Heart Disease

DURATION

Due to

Due to

Other conditions

Broken Compensation

(Include pregnancy within 3 months of death)

Major findings of operations

.....Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Wm E Martin

M. D. or other

Address PandallstownDate signed 5/29/48

RECEIVED

JUN 8 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of birth date shown on:

FILE NO. G

115 MAY 18 1948

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Reg. Dist. No.

1. PLACE OF DEATH

County Baltimore

City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Jan. 31st 1944

8. AGE:

Years 3 Months 3 Days 8 It less than one day hrs. min.

9. Birthplace

Knoxville Tenn.
(Town, county, and state)

10. Usual occupation

11. Industry or business

Hugh W. Ramsey

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

Hugh W. Ramsey

16. Informant

167 Sanford Ave

17. (Burial, cremation, or removal, which?)

Burial Date thereof May 11 1948
(month) (day) (year)

Cemetery or crematorium

St. John's Episcopal Church

Location

Excellis Funeral Home

18. Funeral director

4510 Liberty Heights Ave.

19. (Date rec'd by registrar)

May 18 1948 Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Baltimore

City or town

Catonsville
(If outside city or town limits, write RURAL and give nearest town)

Street No.

117 Sanford Ave
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 8th 1948 at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2 May 1948 to 8 May 1948

and that I last saw him alive on 2 May 1948

Immediate cause of death

Epileptic seizure

Due to

Congenital spastic paralysis

Due to

Mentally deficient

Other conditions

Mentally deficient

(Include pregnancy within 3 months of death)

Major findings of operations

None

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

John A. Nesbitt, Jr. M. D. or other

Address 20 E. Preston St - Dept. 2 Date signed 10 May '48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04272

1. PLACE OF DEATH:

County BaltimoreCity or town Hemington
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 4205 Wilkens Ave
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Mary Runkle

3. (b) Social Security Number

4. Sex

Female

5. Color or race

white

6.(a) Single, married, widowed, or divorced

widow6.(b) Name of husband or wife Late Herman Runkle

6.(c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.) Nov 7, 1858

8. AGE:

Years 89Months 6Days 9

If less than one day

hrs. min.

9. Birthplace

Baltimore Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

Greenwood

13. Birthplace

Germany

MOTHER

14. Maiden name

Germany

15. Birthplace

16. Informant

Mrs Vernon KinkerAddress 4205 Wilkens Ave

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

5/19/48
(month) (day) (year)

Cemetery or crematory

New Catholic

Location

3801 Old Frederick Rd

18. Funeral director

Harry W. WilkinsAddress 4101 E. Amundson Ave

19.

(Date rec'd by registrar)

19 48H. W. Hedrick
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16, 1948 at 4:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 1945 to May 16, 1948and that I last saw her alive on May 12, 1948

Immediate cause of death

DURATION

Arteriosclerotic Cardiovascular Disease

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Earl Pass MD

M. D. or other

Address

400 Wilkens AveDate signed 5-16-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04768 195
Reg. Dist. No.

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 months, 9 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 6 months, 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Howard
 City or town Savage
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

George Reedy

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Daisy Fitch

7. Birth date of deceased (mo., day, yr.) October 27, 1871
 6.(c) If alive, give age 70 years

8. AGE: Years 76 Months 6 Days 7 If less than one day _____ hrs. _____ min.

9. Birthplace Virginia
(Town, county, and state)10. Usual occupation Retired farmer11. Industry or business Farm12. Name Samuel Reedy13. Birthplace Virginia14. Maiden name Betsy Lineweaver15. Birthplace Virginia16. Informant Hospital recordsAddress Catonsville-28, Maryland

17. Burial Date thereof May 6, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Savage CemeteryLocation Savage, Maryland18. Funeral director W. W. WitherspoonAddress Savage, Maryland

19. 5/5/48 19 _____
 (Date rec'd by registrar) Registrar Frank Shipley

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 19 48 at 1:45 a. m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 25 19 47 to May 4 19 48
 and that I last saw him alive on May 4 19 48

Immediate cause of death Cerebral vascular accident DURATION 1 month

Due to Arteriosclerosis, generalized indefinite

Due to _____

Other conditions Senile psychosis 6 months

(Include pregnancy within 3 months of death)

Major findings of operations Multiple trephines of the skull; cerebral atrophy of op. 4-21-48

Autopsy results none
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

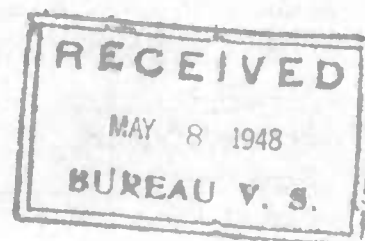
Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury Stroke Injured at work? _____23. SIGNATURE Isadore Tuerk, M.D. M. D. or other _____

Address Catonsville-28, Maryland Date signed 5-4-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

047631

Reg. Dist. No.

1. PLACE OF DEATH:

County BaltimoreCity or town Harrisonville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County BaltimoreCity or town Harrisonville
(If outside city or town limits, write RURAL and give nearest town)Street No. Randalltown P.O.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Louise C. Ritter

3. (b) Social Security Number

#

4. Sex

F.

5. Color or race

W.

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) August 31, 1873

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

7483

hrs.

min.

9. Birthplace

Md.

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

FATHER

12. Name

George Ritter

13. Birthplace

Md.

MOTHER

14. Maiden name

Louise Halbrook

15. Birthplace

Md.

16. Informant

Mrs David Kelly

Address

Randalltown, Md.

17.

(Burial, cremation, or removal, Which?)

Burial

Date thereof

May 5, 1948
(month) (day) (year)

Cemetery or crematory

Mt Paran Cemetery

Location

Halbrook, Balt. Co., Md.

18. Funeral director

C. Henry Wear

Address

Lytleville, Md.

19.

(Date rec'd by registrar)

5/4/

19.

Wm. E. Martin

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 1948 at 4 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1942 to May 3, 1948and that I last saw her alive on May 2, 1948

Immediate cause of death

DURATION

Cardio Vascular Dis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

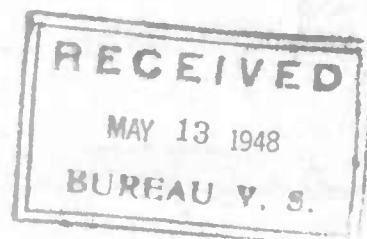
Injured at work?

23. SIGNATURE

Wm. E. Martin

M. D. or other

Address Randalltown Md Date signed 5/4/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04220

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 years, 4 months, 17 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 5 years, 4 months, 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Charles
 City or town Waldorf
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. White Plains, Billingsley P.O.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

James Milburn Robey

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife Addie I. Cox

7. Birth date of deceased (mo., day, yr.) August 27, 1861 6. (c) If alive, give age _____ years

8. AGE: Years 86 Months 8 Days 26 If less than one day _____ hrs. _____ min.

9. Birthplace Maryland
(Town, county, and state)10. Usual occupation Farmer11. Industry or business Farm12. Name Theodore Robey13. Birthplace Maryland14. Maiden name Caroline Wellat15. Birthplace Maryland16. Informant Hospital recordsAddress Catonsville-28, Maryland

17. Burial Date thereof May 26-1948
 (Burial, cremation, or removal) Which (month) (day) (year)

Cemetery or crematory St. Paul's Cem.Location Baden, Md.18. Funeral director Hunt + RyonAddress Waldorf Md.

19. 5-24 19 48 V.E. Harry
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 19 48 at 8:25 p. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 6 19 43 to May 23 19 48
 and that I last saw him alive on May 23 19 48

Immediate cause of death Right broncho pneumonia DURATION 24 hours
Cerebral thrombosis 3 days
 Due to Arteriosclerotic heart disease indefinite

Due to Generalized arteriosclerosis "

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: if death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Isadore Tuerk, M.D.
 M. D. or other _____

Address Catonsville-28, Md. Date signed 5-24-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH: *Baltimore*
County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
6811 Fifth Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State.....*md*..... County.....*Baltimore*
City or town.....*Dundalk*
(If outside city or town limits, write RURAL and give nearest town)
Street No. *6811 Fifth Avenue*
(If rural, give LOCATION)
2. (a) If veteran, name war.....

3. (a) FULL NAME
John B. Rose

3. (b) Social Security Number

4. Sex *M.* 5. Color or race *W.* 6. (a) Single, married, widowed, or divorced *M.*

6. (b) Name of husband or wife *Mary M. Rose* 6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) *January 10, 1898*

8. AGE: Years *50* Months *3* Days *28* If less than one day..... hrs. min.

9. Birthplace.....*Czechoslovakia*
(Town, county, and state)

10. Usual occupation.....*Crane Operator*

11. Industry or business.....*Pethlehem Steel Co.*

12. Name.....*Samuel Rose*

13. Birthplace.....*Czechoslovakia*

14. Maiden name.....*Mary*

15. Birthplace.....

16. Informant.....*Mary M. Rose*

Address.....*6811 Fifth Ave., Dundalk*

17. *Burial* Date thereof.....*May 11, 1948*
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....*Sacred Heart of Mary*

Location.....*German Hill Road, Balto. Co.*

18. Funeral director.....*Roland L. Fisher*

Address.....*2112 Dundalk Ave.*

19. *May 10 1948* *William M. Keely Jr.*
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....*May 8th* 19*48* at *4:45* P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Jan 8* 19*48* to *May 8* 19*48* and that I last saw him alive on *May 7* 19*48*

Immediate cause of death.....*Cancer of Left Lung* DURATION *18 Mos.*

Due to.....*C. Generalized Metastases*

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results..... Date of op.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....*M. Brown* *Mrs*
Address.....*Dundalk* Date signed.....*5/8/48*

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 12 1948

BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlen St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04773 35

1. PLACE OF DEATH:

County Baltimore

City or town Towson
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore

City or town Towson
(If outside city or town limits, write RURAL and give nearest town)

Street No. 8512 Willough Oak Rd.
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Louise Rumpf

3. (b) Social Security Number

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Charles A. Rumpf

6. (c) If alive, give age _____ year

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1868

8. AGE: Years 79 Months 5 Days 28 It less than one day _____ hrs. _____ min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual occupation at home

11. Industry or business

12. Name Jacob Heiger

13. Birthplace Germany

14. Maiden name Rupp

15. Birthplace Germany

16. Informant George Rumpf

Address 1622 N. Regester St.

17. Burial Date thereof 5/18/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Baltimore

Location North Ave & Rose St.

18. Funeral director Clarence F. Hoffmann

Address 1639 Broadway.

19. my 18 x f R. O. Hedrick
(Date rec'd by registrar) (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15, 19 48, at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 7 - 14 to May 15 19 48 and that I last saw him alive on May 14 19 48

Immediate cause of death Myocardial infarction DURATION 1 wk

Due to Chronic arteriosclerosis 2 yrs

Due to Arterio Sclerosis

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Antemortem results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Dr. G. Geyer M. D. or other

Address 156 N. Maltbie Date signed 5/17/48

MARGIN RESERVED FOR BINDING

VS 415 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

97

04774

Reg. Dist. No. 37

1. PLACE OF DEATH:

County BaltimoreCity or town Cockeysville Ind
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 14 years

Hospital, institution, or street address where death occurred:

Masonic Home, Cockeysville Ind

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind CountyCity or town Baltimore Ind
(If outside city or town limits, write RURAL and give nearest town)Street No. 3024 Baker St
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Katherine A. Russell

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Benjamin T. Russell6.(c) If alive, give age 88 years7. Birth date of deceased (mo., day, yr.) Aug. 17 - 1861

8. AGE: Years Months Days It less than one day

86 9 hrs. min.9. Birthplace Washington D. C.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Geo. T. Colison13. Birthplace St. Mary's Co.14. Maiden name Caroline Ferguson15. Birthplace Washington D. C.16. Informant Laura M. SchroederAddress Masonic Home, Cockeysville17. Burial Date thereof May 28 - 48

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Druid RidgeLocation Baltimore Ind18. Funeral director Hon. CookAddress St. Paul + Preston St.19. May 26 - 19 48 L.M. Schroeder

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 19 48 at 12:40 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 47 to May 25 19 48and that I last saw her alive on May 25 19 48

Immediate cause of death

Heart Failure

Due to

Arterio-sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

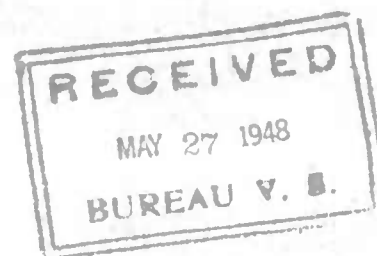
Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Walter T. Kees M.D.Address Cockeysville Ind Date signed 5/25/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04775

1. PLACE OF DEATH:

County BaltimoreCity or town Oundalk
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 23 years

Hospital, institution, or street address where death occurred:

257 Colgate Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County BaltimoreCity or town Oundalk
(If outside city or town limits, write RURAL and give nearest town)Street No. 257 Colgate Ave
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Joseph John Ruzakowski

3. (b) Social Security Number

213-07-0234

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Bernice8. (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.)

19 March 1980

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Poland

(Town, county, and state)

10. Usual occupation

Steel worker

11. Industry or business

MOTHER

12. Name

John Ruzakowski

13. Birthplace

Poland

14. Maiden name

~~Bernice~~ Mary Burdinski

15. Birthplace

Poland

16. Informant

Joseph W. Ruzakowski

Address

257 Colgate Ave.Burial
(Burial, cremation, or removal, Which?)

Date thereof

May 18/48
(month) (day) (year)

Cemetery or crematory

St. Mary's

Location

Baltimore

18. Funeral director

Fred W. Ozaszewski

Address

1930 Eastern Ave

19.

5/17/48
(Date rec'd by registrar)48AS Helmer
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 May 19 48 at 4:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 1947 to 14 May 1948and that I last saw him alive on 13 May 19 48

Immediate cause of death

Cancer of stomach

DURATION

1 year

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Cancer of stomach

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dr. J. Edward M. S.
M. D. or otherAddress 8 Liberty Parkway Date signed 14 May 48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04776

Reg. Dist. No. 43

1. PLACE OF DEATH:

County Baltimore
 City or town Raspeburg, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? life
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Raspeburg, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4608 Ridgeway Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

WALTER C. SCHILLER

3. (b) Social Security Number

216-01-3576

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Clara E. Schiller
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Nov. 13th, 1885
 8. AGE: Years 62 Months 6 Days 7 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore County, Md.
 (Town, county, and state)
 10. Usual occupation Machinist
 11. Industry or business Murrill Keizer Employee Co.

MOTHER FATHER
 12. Name Bernhardt Schiller
 13. Birthplace Baltimore, Md.
 14. Maiden name Agnes C. Schiller
 15. Birthplace Baltimore, Md.

16. Informant Mrs. W.C. Schiller
 Address 4608 Ridgeway Ave.

17. burial Date thereof 5/22/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Moreland Memorial Park
 Location Baltimore, Md.

18. Funeral director Lassahn Funeral Home
 Address 7401 Belair Rd.

19. 5/21 48 D.W. Hedrick
 (Date rec'd by registrar) (year) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20th, 1948, at 3:10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10 1948 to May 20 1948 and that I last saw him alive on May 19 1948

Immediate cause of death Acute heart failure

Due to Coronary thrombosis

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Edmund J. Lewis M. D. or other

Address 6232 Belair Road Date signed May 20, 1948

DURATION

(week)

3 weeks

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville-28
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? since November 17, 1938
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? since November 17, 1938

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 3809 Ridgecroft Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

SCHNEIDER
Catherine SCHNEIDER

3. (b) Social Security Number

4. Sex F. 5. Color or race W 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Robert A. Schneider
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) 7/5/1869
 8. AGE: Years 78 Months 10 Days 10 If less than one day _____ hrs. _____ min.
 9. Birthplace Maryland
 (Town, county, and state)
 10. Usual occupation Housework
 11. Industry or business _____

MOTHER FATHER
 12. Name William Franke
 13. Birthplace Germany
 14. Maiden name Caroline Misoler
 15. Birthplace Germany

16. Informant Hospital records
 Address Spring Grove State Hospital

17. Burial Date thereof 5-19-48
 (Burial, cremation, or removal, which) (month) (day) (year)
 Cemetery or crematory Parkwood
 Location 3310 Taylor Ave

18. Funeral director Wm. Cook Inc.
 Address 1217 St. Paul St

19. 5/12 58 A. W. Hedrick
 (Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15, 1948 19____, 5, 35 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____, to _____ 19____
 and that I last saw him _____ alive on _____ 19____

Immediate cause of death _____ DURATION _____
Cardiac Failure
 Due to _____
Cardiovascular disease
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Ch. Smkieffer Deputy
 M. D. or other _____
 Address 1010 Leeds an Date signed 5-15-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 468-04778 48

1. PLACE OF DEATH:

County..... **Baltimore**
 City or town..... **Fort Howard**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... **39 Days**
 Hospital, institution, or street address where death occurred:
Vets. Adm. Hospital, Ft. Howard, Maryland
 How long in hospital or institution?..... **39 Days**

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... **Maryland** County..... **Baltimore**
 City or town..... **Baltimore**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. **2905 E. Baltimore St.**
 (If rural, give LOCATION)
 2(a) If veteran, name war..... **WW II**

3. (a) FULL NAME

WILLIAM P. SCHORN3. (b) Social Security Number
216-05-9063

4. Sex..... **Male**
 5. Color or race..... **White**
 6. (a) Single, married, widowed, or divorced..... **Married**

6. (b) Name of husband or wife..... **Mary Frances Schorn**
 7. Birth date of deceased (mo., day, yr.)..... **7/4/1900**
 6. (c) If alive, give age..... **42** years

8. AGE: Years..... **47** Months..... **10** Days..... **17**
 If less than one day..... hrs. min.

9. Birthplace..... **Baltimore County, Md.**
 (Town, county, and state)

10. Usual occupation..... **Insurance**

11. Industry or business

12. Name..... **Adolph Schorn**

13. Birthplace..... **Germany**

14. Maiden name..... **Regina Pfaff**

15. Birthplace..... **Maryland**

16. Informant..... **Registrar's Office, Vets. Adm. Hospital**
 Address..... **Fort Howard, Maryland**

17. **burial** Date thereof..... **May 24 1948**
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... **Greenmount Cemetery**

Location..... **Greenmount Ave., and Oliver St.**

18. Funeral director..... **Moran Funeral Home**

Address..... **3000 E. Baltimore & Potomac St.**

19. **may 24 1948** **A. W. Hedrick**
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **May 21** 19 **48** at **7:15 AM**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **April 12** 19 **48** to **May 21** 19 **48**
 and that I last saw him alive on **May 21** 19 **48**

Immediate cause of death..... **Gastric neoplasm with ulceration and hemorrhage.**

Due to..... **The neoplasm was cancerous.**

Due to.....

Other conditions..... **None**

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results..... **None**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... **H. C. Manaugh**
H. C. MANAUGH, M. D., Chf. Prof. M. Serv.
VAH Ft. Howard, Maryland
 Address..... Date signed..... **5/21/48**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

04779

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 21 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Glen Arm
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

John Milton Schwatka

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Emma O. Schwatka
 6.(c) If alive, give age Unknown years
 7. Birth date of deceased (mo., day, yr.) September 4, 1870
 8. AGE: Years 77 Months 8 Days 17 If less than one day _____ hrs. _____ min.
 9. Birthplace Baltimore, Maryland
 (Town, county, and state)
 10. Usual occupation Painter
 11. Industry or business For Self
 12. Name William F. Schwatka
 13. Birthplace Baltimore, Maryland
 14. Maiden name Caroline Maize
 15. Birthplace Iowa

16. Informant Hospital records
 Address Catonsville, 28, Md.
 17. Burial Date thereof 5/24/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Waugh Cemetery
 Location Long Green Rd (Balto Co.)
 18. Funeral director John J. Cowan & Son
 Address 901-03 Hollins St.
 19. May 24, 1948 A. W. Hefner
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21, 1948 19____ at 8:05 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 30 1948 to May 21, 1948
 and that I last saw him alive on May 21, 1948 19____

Immediate cause of death
Arteriosclerotic heart disease DURATION Indefinite
 Due to Generalized arteriosclerosis n
 Due to Hypertensive cardio-vascular disease n
 Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. _____

Autopsy results None
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE Isadore Tuerk, M.D. M. D. or other _____
 Address Ca onsville, 28, Md. Date signed 5/22/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

04780

43

1. PLACE OF DEATH:

Baltimore
County.....
City or town.....Raspeburg, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....30 years
Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Maryland County.....Baltimore
City or town.....Raspeburg, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.....11 Cliftwood Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3.(a) FULL NAME

ARTHUR M. SCOTT, Sr.

3.(b) Social Security Number

219-18-0916

4. Sex.....male 5. Color or race.....white 6.(a) Single, married, widowed, or divorced.....married
6.(b) Name of husband or wife.....Wanda C. Scott
6.(c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.).....Feb. 17th, 1886
8. AGE: Years.....62 Months.....2 Days.....26 If less than one day..... hrs. min.

9. Birthplace.....Baltimore, Md.
(Town, county, and state)
10. Usual occupation.....Huckster
11. Industry or business.....

FATHER 12. Name.....Wm. W. Scott
13. Birthplace.....Baltimore, Md.
MOTHER 14. Maiden name.....Florence Livery
15. Birthplace.....Baltimore, Md.

16. Informant.....Mrs. A.M. Scott, Sr
Address.....11 Cliftwood Ave.

17. burial Date thereof.....5/17/48
(Burial, cremation, or removal. Which?)..... (month) (day) (year)
Cemetery or crematory.....Baltimore
Location.....Baltimore, Md.

18. Funeral director.....Lassahn Funeral Home
Address.....7401 Belair Rd.

19. May 14 1948 Thos. P. L. Reifsnider
(Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....May 13th, 1948, at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1st 1948 to May 13 1948
and that I last saw him alive on May 10th 1948

Immediate cause of death.....

DURATION

Angina Pectoris 1 day
Due to.....Coronary Disease 7 months
Due to.....arterio-sclerosis 2 yrs
Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE.....W. O. O'Brien M. D. or other

Address.....W. O. O'Brien Date signed.....5/14/48

RECEIVED

MAY 19 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The format age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH 950

04781

Reg. Dist. No.

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Approx. 12 hrs.

Hospital, institution, or street address where death occurred:

Vets. Adm. Hospital, Ft. Howard, Md.How long in hospital or institution? Approx. 12 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 7 E. Montgomery St. Balto. 30, Md.
(If rural, give LOCATION)2. (a) If veteran, name war WW-1

3. (a) FULL NAME

CLARENCE W. SHAKESPEARE

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single6. (b) Name of husband or wife Single

7. Birth date of deceased (mo., day, yr.)

November 23, 1899

8. AGE: Years Months Days It less than one day

4858

hrs.

min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)10. Usual occupation unemployed

11. Industry or business

12. Name Walter Shakespeare13. Birthplace Maryland14. Maiden name Amelia Lees15. Birthplace Maryland16. Informant Clinical Records, Vets. Adm. Hosp.Address Fort Howard, Maryland17. BURIAL Date thereof 5/4/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Loudon Park CemeteryLocation Frederick Rd. Balto., Md.18. Funeral director John F. DennyAddress Light & Montgomery St. Baltimore, Md.19. 5/4 19 48 A.W. Hedrick
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

Unknown

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 1948 at 12:45 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 30 1948 to May 1 1948and that I last saw him alive on May 1 1948Immediate cause of death Pulmonary EmphysemaAtalectasis, & EdemaCause unknown

Due to

Due to

Due to

Due to

Other conditions Passive congestion ofViscera, Hydrothorax, Ascites.Cardiac Dilatation & Hypertrophy.

Major findings of operations

Date of op.

Autopsy results Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE W.W. Shacklett, M.D.Address Fort Howard, Md. Date signed

DURATION

12 Hrs.PlusUnknown

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

04782

546

37

1. PLACE OF DEATH:

County Baltimore

City or town Glencoe - Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County Balt -

City or town Glencoe
(If outside city or town limits, write RURAL and give nearest town)

Street No. Glencoe - Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

BEMENT = PARKER = SHARP II

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) MARCH 16 - 1941

8. AGE: Years 7 Months 1 Days 23 It less than one day - hrs. - min.

9. Birthplace Baltimore - Md.
(Town, county, and state)

10. Usual occupation At - School

11. Industry or business "

12. Name Alfred E. Sharp

13. Birthplace MARYLAND

14. Maiden name MARY E. Bubb

15. Birthplace PA.

16. Informant Alfred E. Sharp

Address Glencoe - Md

17. Burial Date thereof 11 MAY 48
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Landon Park

Location Baltimore Md

18. Funeral director F.B. Wipbert & Son

Address 1300 E. 4th St. - 17

19. May 11 1948 Registrar G. D. Deluch

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 9 19 48 at 12 30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 47 to MAY 19 48

and that I last saw him alive on May 9 19 48

Immediate cause of death TUMOR OF BRAIN

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Malignant Brain tumor

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE G. H. France M. D. or

Address Partim, Md Date signed 5/10/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

35

1. PLACE OF DEATH:

County Baltimore
City or town White Hall Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 65 years
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new born infants give residence of mother)

State Ind County Baltimore
City or town White Hall Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Clarence Raymond Shaw

3. (b) Social Security Number

NONE

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male col Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February, 22 / 1882

8. AGE: Years Months Days If less than one day
66 2 22 hrs. min.

9. Birthplace Hanford Co Ind
(Town, county, and state)

10. Usual occupation Farm laborer

11. Industry or business

12. Name Mrs Shaw

13. Birthplace Pa

14. Maiden name Hannah Mary Selinsky

15. Birthplace Pa

16. Informant Walter Shaw

Address White Hall Ind

17. Burial Date thereof May 15 - 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Pine Grove

Location White Hall Rural

18. Funeral director Howard S. Markline

Address White Hall Ind

19. May 14 19 48 Registrar Mrs Howard S. Markline

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 19 48 at 3³⁰ P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 19 48 to May 12 19 48

and that I last saw alive on May 11 19 48

Immediate cause of death Hypertensive C. V. Disease

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

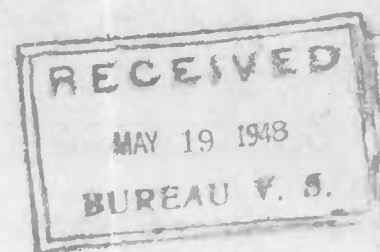
23. SIGNATURE A. M. France M. D. or other

Address Parthia Ind Date signed 5/14/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:

County Baltimore County
 City or town Rural near Baltimore City
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death 7 years
 Hospital, institution, or street address where death occurred:
3515 Meadowside Road
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)
 State Maryland County Baltimore Co
 City or town Rural near Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 3515 Meadowside Rd.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Lillian May Sheckells

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow
 6. (b) Name of husband or wife John Charles Sheckells
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Nov. 22 1869
 8. AGE: Years 78 Months 6 Days 0 If less than one day _____ hrs. _____ min.

9. Birthplace Maryland
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business own home
 12. Name Robert Edmondston
 13. Birthplace Maryland
 14. Maiden name Annie ?
 15. Birthplace Maryland

16. Informant Mrs. Wisdom L. Perry (daughter)
 Address 3515 Meadowside Rd.
 17. Burial Date thereof 5-25-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Woodlawn
 Location Woodlawn Md
 18. Funeral director Wm. J. Fickner Sons
 Address Mt. Aves.
 19. May 25 1948 A. W. Hegner
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1948 at 1 P.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 15 1941 to May 22 1948
 and that I last saw her alive on May 21 1948
 Immediate cause of death Chronic Myocardial Degeneration DURATION 7 years
 Due to Diabetes 7 years
 Other conditions Senility
 (Include pregnancy within 3 months of death)
 Major findings of operations No Operation Date of op. _____
 Autopsy results No autopsy
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE Joshua H. Armacost MD
6419 Windsor Mill Rd M.D. or other _____
 Address _____ Date signed May 22 1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04785

1. PLACE OF DEATH:

County... BALTO
 City or town... KENSINGTON
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4212 KENSINGTON RD
 Hospital, institution, or street address where death occurred: 4212 KENSINGTON RD

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... MD County... BALTO
 City or town... KENSINGTON
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4212 KENSINGTON RD
 (If rural, give LOCATION)

2.(a) If veteran, name war No

3. (a) FULL NAME

CHARLES E. SHEEHAN JR.

3. (b) Social Security Number

213-03-0745

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

M6. (b) Name of husband or wife THERESA M. SHEEHAN

7. Birth date of deceased (mo., day, yr.)

1/13/1959

8. (c) If alive, give age... years

8. AGE:

Years

Months

Days

If less than one day

5943hrs.min.

9. Birthplace

BALTIMORE, MD.
(Town, county, and state)

10. Usual occupation

FOREMAN

11. Industry or business

MD. PRINTING & PUBL. CO.

12. Name

WM. SHEEHAN

13. Birthplace

BALTO, MD.

14. Maiden name

MARY ANN DOLAN

15. Birthplace

BALTO, MD.

16. Informant

CHARLES E. SHEEHAN JR.

Address

2704 WINCHESTER RD.

17. Burial

BURIAL
(Burial, cremation, or removal. Which?)

Date thereof

5/19/48
(month) (day) (year)

Cemetery or crematory

NEW CATHEDRAL

Location

BALTO, MD.

18. Funeral director

WM. T. TICKNER & SONS

Address

BALTO, MD.

19. 5/18

5/18
(Date rec'd by registrar)

19. 5/18

Dr. W. Hedrick
Registral

MEDICAL CERTIFICATION

20. DATE OF DEATH

5/161948at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

march 10 1948 to may 16 1948
and that I last saw him alive on may 13 1948

Immediate cause of death

Coronary Thrombosis

DURATION

Due to

Due to

Other conditions

Chronic Bronchitis

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

(injured at home, farm, industry, public place (where?))

Means of injury

injured at work?

23. SIGNATURE

Albert Scagnotti

M. D. or other

Address

1729 W. Lombard St

Date signed

May 18 48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

04793

1. PLACE OF DEATH:

County Balto.
 City or town Sparrows Point
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? (Elkmore)
 Hospital, institution, or street address where death occurred:
2515 Brammon Ave.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Elkmore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2515 Brammon Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Gary Wayne Short.

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

May 24/1948.

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

2 hrs.

min.

9. Birthplace

Balto. Co. Sparrows Point.
(Town, county, and state)

10. Usual occupation

None

11. Industry or business

FATHER

12. Name

Albert Short.

13. Birthplace

Clendenin W. Va.

MOTHER

14. Maiden name

Shirley Payne.

15. Birthplace

Clendenin W. Va.

16. Informant

Albert Short.

Address

At home

17.

(Burial, cremation, or removal. Which?)

Date thereof

May 25, 1948
(month) (day) (year)

Cemetery or crematory

Baltimore County Home

Location

Texas, Md.

18. Funeral director

Roland L. Fisher

Address

2112 Dundalk Ave.

19.

(Date received by registrar)

May 24 - 1948
Darwin L. Fisher
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 24, 1948, at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 24, 1948, to 19and that I last saw him alive on 19

Immediate cause of death

Allolectasis

Due to

Spiria Bifida

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. McCarroll, M.D.
Deputy Medical Examiner
Address Balto. Co. Dundalk Ave. Date 5/24/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:

County Baltimore

City or town Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs., 0 mos., 1 day

Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. T. B. Sanatorium

How long in hospital or institution? 4 yrs., 0 mos., 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No. 311 S. Madeira Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Erwin Joseph Sickoria (Sickora)

3. (b) Social Security Number

217-18-9568

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 15, 1924

8. AGE: Years 24 Months 3 Days 20 If less than one day hrs. min.

9. Birthplace Trenton, New Jersey
(Town, county, and state)

10. Usual occupation Factory-Machine Operator

11. Industry or business

12. Name Michael Sickoria

13. Birthplace Poland

14. Maiden name Julia Shorber

15. Birthplace Poland

16. Informant Erwin Joseph Sickoria

Address 311 S. Madeira St., Balto., Md.

17. Burial Date thereof May 10, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Sacred Heart Cemetery

Location German Hill Rd., Balto., Md.

18. Funeral director Dipple Bros.

Address 1800 E. Lombard St., Balto., Md.

19. May 5, 1948
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5, 1948 at 6:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 4, 1948 to May 5, 1948 and that I last saw him alive on May 5, 1948

Immediate cause of death Pulmonary Tuberculosis DURATION 6 yrs.

Due to Tubercle Bacilli

Due to

Other conditions Tuberculous Laryngitis 1 yr.

Tuberculous Enteritis 1 yr.

(Include pregnancy within 6 months of death)
Tuberculous Otitis Media, 4 mos.

Major findings of operations None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Stewart S. Shaffer M.D. M. D. or other

Address Mt. Wilson, Md. Date signed 5/5/48

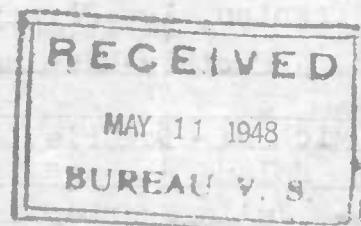
MARGIN RESERVED FOR BINDING

VS A16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1700

04787

Reg. Dist. No. 33

1. PLACE OF DEATH:

County Baltimore
 City or town Reisterstown
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Hanover Road-1 mi. N. of Reis.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 213 N. Pine St.
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Robert Harry Smith

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Colored

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Maggie P. Smith

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

Feb. 16, 1920

8. AGE:

Years

Months

Days

If less than one day

283

_____ hrs.

_____ min.

9. Birthplace

Baltimore City

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

FATHER

12. Name

Albert Smith

13. Birthplace

Md.

MOTHER

14. Maiden name

Marie Brown

15. Birthplace

Md.

16. Informant

Maggie P. Smith

Address

213 N. Pine St. Baltimore, Md.

17.

Buried
(Burial, cremation, or removal, Which?)

Date thereof

May 20 48
(month) (day) (year)

Cemetery or crematory

Not Calvary

Location

Baltimore City

18. Funeral director

Address

918 Grand Hallway

19.

5-17
(Date rec'd by registrar)1948Mary B. Eline
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1948 at 2:45A. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-15-48 to 5-15-48

and that I last saw him alive on _____ not seen alive _____

Immediate cause of death

Fractured Cervical VertebraFractured Rt. FemurLacerations of eyebrow, scrotum, rt. arm & chin

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

NONE

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 5-15-48Where did injury occur? Reisterstown, Balto., Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Hanover Rd.-1 mi.Means of injury Auto. Accident Injured at work? N. of Reis.

23. SIGNATURE

Dr. A. D. Caples Med Exam
M. D. or otherAddress Reisterstown, Md. Date signed 5-15-48

RECEIVED

MAY 19 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04788

Reg. Dist. No. 31

1. PLACE OF DEATH:

County BaltimoreCity or town Randallstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Randallstown
(If outside city or town limits, write RURAL and give nearest town)Street No. Migans Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Annie Stacey Smoot

3. (b) Social Security Number

None

4. Sex <u>F</u>	5. Color or race <u>W</u>	6.(a) Single, married, widowed, or divorced <u>Widow</u>
--------------------	------------------------------	---

6.(b) Name of husband or wife Frank Smoot

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26, 1869

8. AGE:	Years	Months	Days	If less than one day
	<u>79</u>	<u>0</u>	<u>8</u>	hrs. min.

9. Birthplace Virginia
(Town, county, and state)10. Usual occupation At Home

11. Industry or business

12. Name Unknown

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant Mrs. Roy MeekinsAddress Randallstown, Md.17. Burial Date thereof 5-7-48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt. OliveLocation Randallstown, Md.18. Funeral director F. C. HiginbothamAddress Ellicott City, Md.19. 3/4 1948 Mr. E. Martin
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4, 1948 at 8 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 5, 1946 to May 1948and that I last saw her alive on May 1948

Immediate cause of death

Coronary OcclusionCardiovascular Dis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Mr. E. Martin M. D. or otherRandallstown Date signed 3/4



Dr. Grott

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04789 3

1. PLACE OF DEATH:

County... Overlea

City or town... Baltimore
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

7548 Belair Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Overlea

City or town... Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 7548 Belair Road
(If rural, give LOCATION)

2.(a) If veteran, name war...

3.(a) FULL NAME

Henry H. Sparr

3.(b) Social Security Number

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

Emma M. Sparr

7. Birth date of
deceased (mo., day, yr.)

March 11, 1875

6.(c) If alive, give age... years

8. AGE:

Years

Months

Days

If less than one day

73

1

21

hrs.

min.

9. Birthplace

Phila, Pa.

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

MOTHER FATHER

12. Name

Adam Sparr

13. Birthplace

Switzerland

14. Maiden name

?

15. Birthplace

?

16. Informant

Mrs. Emma M. Sparr

Address

7548 Belair Road

17.

Burial

(Burial, cremation, or removal, Which?)

Date thereof

5-5-48

(month) (day) (year)

Cemetery or crematory

Parkwood

Location

Baltimore

18. Funeral director

Leonard J. Ruck

Address

5305 Harford Road, #14

19.

(Date rec'd by Registrar)

19

48

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 2nd.

19 48

at 11 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

9 am. 19 45 to May 2, 19 48
and that I last saw him alive on May 1, 19 48

Immediate cause of death

Coronary Thrombosis

DURATION

1 M.O.

Due to

Atherosclerotic Cardio-

Due to Vascular disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Harold A. Grott, M.D.

M. D. or other

Address

5305 Harford Rd.

Date signed

5/3/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *172* *04790* *46*

1. PLACE OF DEATH

County *Balto*
City or town *Middle River*
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md.* County
City or town *Balto*
(If outside city or town limits, write RURAL and give nearest town)
Street No. *1520 N. Gay St.*
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Geo. C. Stagmer

3. (b) Social Security Number

4. Sex *M.* 5. Color or race *W.* 6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife *Marg. C. Stagmer*
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Jan. 3 - 1897*
8. AGE: Years *51* Months Days If less than one day
hrs. min.

9. Birthplace *Balto., Md.*
(Town, county, and state)

10. Usual occupation *Owner & operator*
11. Industry or business *Own Motor sales service*

12. Name *Jeffie B. Stagmer*
13. Birthplace *Md.*

14. Maiden name *Blanche Taylor*
15. Birthplace *Balto., Md.*

16. Informant *Mrs. Marg. C. Stagmer*
Address *1520 N. Gay St.*

17. (Burial, cremation, or removal, Which?) *Burial* Date thereof *May 20 - 1948*
(month) (day) (year)

Cemetery or crematory *Holy Redeemer*
Location *Belair Rd.*

18. Funeral director *Wm. J. Tichner*
Address *North & Pennsylvania Ave.*

19. (Date rec'd by registrar) *May 20 - 48* *John B. Connelley* Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *5/17/48* 19 *20* at *9* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19 *19* and that I last saw him *alive on* 19 *19*

Immediate cause of death *Asphyxiation* DURATION *3 hrs*

Due to *Shown from Spinal tract.*
Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: *5/16/48*
Accident, suicide, or homicide *Accident* Date of *5/16/48*
Where did injury occur? *Middle River, Balto., Md.* (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) *Public Place*
Means of injury *Shown from Spinal tract* Injured at work? *no*

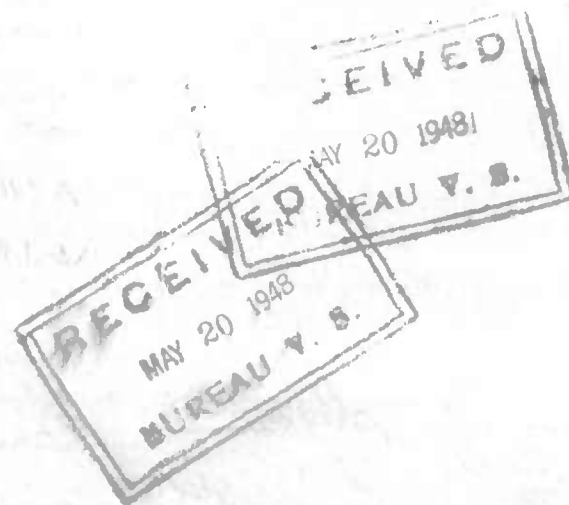
23. SIGNATURE *M. B. Davis M.D.* Date signed *5/17/48*
Address *1520 N. Gay St.* Date signed

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH
 County Baltimore
 City or town Woodlawn
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Caroline D. Stausenmayer4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Charles F. Stausenmayer7. Birth date of deceased (mo., day, yr.) Feb. 4 1868 6. (c) If alive, give age 41 years8. AGE: 80 Years 3 Months 4 Days If less than one day hrs. min.9. Birthplace Germany
(Town, county, and state)10. Usual occupation School teacher11. Industry or business School12. Name Quetlaw Weber13. Birthplace Germany14. Maiden name Quetlaw Grammell15. Birthplace Germany16. Informant Mr. Martin J. HendricksAddress 18 Summerfield Rd. Woodlawn17. Burial (Burial, cremation, or removal, which?) Burial Date thereof May 11 1948
(month) (day) (year)Cemetery or crematorium Greenwood CemeteryLocation Baltimore, Md.18. Funeral director E. Ellis LamoreauAddress 4510 E. 10th St. N. Heights Ave.19. May 10 1948 Q. J. Delaich
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Md. County BaltimoreCity or town Woodlawn
(If outside city or town limits, write RURAL and give nearest town)Street No. 18 Summerfield Road

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8 1948 at 11:50 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 11 1941 to May 4 1948and that I last saw him alive on May 4 1948Immediate cause of death Chronic myocarditisDURATION 10 yrs.Due to arteriosclerosis 15 yrs.Due to Cerebral arteriosclerosis 12 yrs.Other conditions Cerebral arteriosclerosis

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. C. Delaich M. D. or otherAddress 3403 Pomeroy Blvd. Date signed 5/10/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04792 44

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 16 days

Hospital, institution, or street address where death occurred:

Veterans Administration HospitalHow long in hospital or institution? 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 1804 N. Chapel St.
(If rural, give LOCATION)2.(a) If veteran, name war WWII

3. (a) FULL NAME

FREDERICK P. STEIN

3. (b) Social Security Number

Unknown 212-14-0742

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MaleWhiteMarried6. (b) Name of husband or wife Irma Stein6. (c) If alive, give age 23 years7. Birth date of deceased (mo., day, yr.) 6-5-218. AGE: Years 26 Months 11 Days 4 If less than one day
..... hrs. min.9. Birthplace Baltimore, Maryland
(Town, county, and state)10. Usual occupation Mail Carrier

11. Industry or business

12. Name Frank Stein13. Birthplace Baltimore, Maryland14. Maiden name Ethel Webster15. Birthplace Baltimore, Maryland16. Informant Clinical Records, Vets. Adm. HospAddress Ft. Howard, Md.17. Burial Date thereof 5-12-48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Oak Lawn CemeteryLocation Eastern Ave. Baltimore, Md.16. Funeral director Frederick Miller, Inc.Address 3019 E. Monument St. Balto., Md.19. May 11 19 48
(Date rec'd by registrar) Registrar ma

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 19 48 6:31 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
April 23 19 48 to May 9 19 48and that I last saw him alive on May 9 19 48Immediate cause of death CEREBRO-VASCULAR ACCIDENT

DURATION

UNKNOWN

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Joseph Alvarez M. D. or otherAddress Ft. Howard, Md. Date signed

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 31

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 5410 Gwynnsdale Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town 5410 Gwynnsdale Ave
(If outside city or town limits, write RURAL and give town)(d) Street No. Balto. Md.
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Herbert Garfield Stine

3 (b) If veteran, name war

None

3 (c) Social Security Account

No 217-20-5981

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Eunice Maria Margaret

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 30, 1880

8. AGE: Years Months Days If less than one day

68 hr. min.

9. Birthplace Wash. Co. Md.

(Town, county, and state)

10. Usual Occupation Prof. Amusement Devices

11. Industry or business

12. Name Thomas Luther Stine

13. Birthplace Md.

14. Maiden Name Clara Mullendore

15. Birthplace Md.

16 (a) Informant Eunice Maria Margaret Stine

(b) Address 5410 Gwynnsdale Ave

17 (a) Burial (b) Date thereof May 5, 1948

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Balto. Co. Md.

18 (a) Funeral director Wm. J. Teller & Son

(b) Address Balto. Md.

MAY 4 - 1948

(Date rec'd by registrar)

Huntington Hall, Md.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/1/48 at 9 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1947 to May 1, 1948.

and that I last saw him alive on May 1, 1948.

Immediate cause of death

Cancer Head Pancreas

Duration 1 yr.

Due to

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Feb 24 - 1948

Major findings of operation: Cancer

Head Pancreas.

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature H. H. Schneider

Address 104 W. Madison St.

Date signed 5/3/48

PHYSICIAN

Underline the cause to which death should be charged statistically.

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE

cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see **PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION** issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH *93d*Reg. Dist. No. *40*

04795

1. PLACE OF DEATH

County *Baltimore*City or town *Bradshaw*
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? *four months*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Thomas Jefferson Sullivan

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

May 11, 1981

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

67

hrs.

min.

9. Birthplace

West Virginia
(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

FATHER

12. Name

Michael Sullivan

13. Birthplace

W. Va.

MOTHER

14. Maiden name

Unknown

15. Birthplace

16. Informant

Mrs. Elizabeth Sullivan

Address

Bradshaw Rd.

17.

(Burial, cremation, or removal, which?)

Date thereof

May 26 1948
(month) (day) (year)

Cemetery or crematory

Oaklawn Cems.

Location

Balto Md.

18. Funeral director

Clarence E. Arthur

Address

York Md.

19.

May 24 1948
(Date rec'd by registrar)*G. E. Arthur*

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Balto.

City or town

Bradshaw
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 24 1948, at *11 A.* M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

None

and that I last saw h

None

Immediate cause of death

*Heart disease
chronic, vascular, coronary disease
with occlusion.*

DURATION

5/24/48

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Rollin C. Hudson M.D. DNE.

M. D. or other

Address

Towson Md.

Date signed

5/24/48

RECEIVED

MAY 29 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *38*

04796

1. PLACE OF DEATH:

County *Balto*
 City or town *Annapolis*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
7005 Coppleigh Rd
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State *Md* County *Balto*
 City or town *Annapolis*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. *7005 Coppleigh Rd*
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Grace M. Lyon Tarman

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female *White* *Married*

6. (b) Name of husband or wife

Clarence E. Tarman

7. Birth date of deceased (mo., day, yr.)

Sept 3rd 1890

8. AGE: Years Months Days If less than one day

57 *8* *15* hrs. min.

9. Birthplace

Balto. Md.
 (Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Own Home

12. Name

Oliver Parker Lyon

13. Birthplace

Balto. Md.

14. Maiden name

Emma G. Miller

15. Birthplace

Balto. Md.

16. Informant

Clarence E. Tarman

Address

7005 Coppleigh Rd.

17. (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Burial *5/20/48*

Cemetery or crematory

Green Mount

Location

Balto. Md.

18. Funeral director

William Cook Inc.

Address

1217 St. Paul St.

19. (Date rec'd by registrar)

5/19 *48* *D. W. Hedrick*
 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *May 18th 1948* at *2:15* P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1946 to *5-18-1948*
 and that I last saw him alive on *5-18-1948*

Immediate cause of death

Cerebral Hemorrhage *3 hrs*
2 Angina Pectoris *3 hrs*
Hypertension *unknown*

Due to *Previous Cerebral Hemorrhage*

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *C. B. Evers* M. D. or otherAddress *7201 York Rd* Date signed *5-19-48*

W. W. Cook Inc.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

04797

44

172

1. PLACE OF DEATH:

County Balts

City or town Middle River
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balts

City or town Middle River
(If outside city or town limits, write RURAL and give nearest town)

Street No. E 4 Alder Drive
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Claire Anna Teske

3. (b) Social Security Number

171-16-6985

4. Sex F 5. Color or race W. 6.(a) Single, married, widowed, or divorced —

6.(b) Name of husband or wife Lawrence

7. Birth date of deceased (mo., day, yr.) January 16-1918 6.(c) If alive, give age years

8. AGE: Years 30 Months — Days — It less than one day hrs. min.

9. Birthplace M^c Keesport Penna
(Town, county, and state)

10. Usual occupation Clerk

11. Industry or business Glenn L. Martini Co.

12. Name Charles Engelbrecht

13. Birthplace Penn

14. Maiden name M^c Kee

15. Birthplace Penna

16. Informant Mr. Lawrence - Teske

Address E. 4 - Alder Drive

17. Removal Date thereof 5-18-48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory M^c Keesport

Location Penna

18. Funeral director John S. Connelly

Address 418 Eastern Ave.

19. 5-17-48 19. John S. Connelly
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/16/48 19. at 11:50 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw h. alive on 19.

Immediate cause of death

Due to Stroke from heart

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 5/16/48

Where did injury occur Middle River, Balts, Md
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Public Place

Means of injury Thrown from bed Injured at work? No

23. SIGNATURE John S. Connelly M.D. or other

Address 418 Eastern Ave. Date signed 5/17/48

MARGIN RESERVED FOR BINDING

9.45-15M

VS 415

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 20 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 43

04798

94a

1. PLACE OF DEATH:

County Balto.

City or town Overlea
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Overlea
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1 Madeline Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

George R. Thater

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Elizabeth

7. Birth date of deceased (mo., day, yr.)

Aug 20 1870

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

77 7 8 18 hrs. min.

9. Birthplace

Balto.
(Town, county, and state)

10. Usual occupation

TURNKEY

11. Industry or business

COUNTY POLICE, DEPT.

FATHER

12. Name

Phillip Thater

FATHER

13. Birthplace

Balto.

MOTHER

14. Maiden name

Bertha E.

MOTHER

15. Birthplace

?

16. Informant

William F. G. Thater

Address

1 Madeline Ave

17. BURIAL

Date thereof

MAY 9 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

HOLY CROSS BROOKLYN

Location

RICHIE HIGHWAY

18. Funeral director

DIPPEL BROTHERS

Address

7110 BELAIR RD.

19. 5-8

(Date rec'd by registrar)

19 48

George R. Thater

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 6 1948 at 2:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

8 spine

1947 to 6 May 1948

and that I last saw him alive on 6 May 48

Immediate cause of death

Coronary occlusion

DURATION

6 hrs.

Due to

Due to

Other conditions

Atherosclerosis, generalized atherosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

none

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Edward L. J. Thater

Date signed

Address

7329 Harford Rd.

7 May 48

MARGIN RESERVED FOR BINDING

I

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:

County Baltimore
 City or town Mount Wilson
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 yrs., 1 mo., 20 days
 Hospital, institution, or street address where death occurred Mt. Wilson
Branch, Md. T. B. Sanatorium
 How long in hospital or institution? 2 yrs., 1 mo., 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Howard Co.
 City or town Jessups, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Albert A. Thurston

3. (b) Social Security Number

705-03-6183

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

8. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) March 22, 1887

8. AGE: Years 61 Months 1 Days 25 If less than one day _____ hrs. _____ min.

9. Birthplace Virginia
 (Town, county, and state)

10. Usual occupation Boiler Maker's Helper

11. Industry or business

12. Name Thomas Thurston13. Birthplace Virginia14. Maiden name Susian Garrison15. Birthplace Virginia16. Informant Albert A. ThurstonAddress Jessups, Howard Co., Md.

17. Burial Date thereof 5/19/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Meadow Ridge Mem. Pk.Location Near Dorsey, Howard Co., Md.18. Funeral director John J. Cowan & SonAddress 901 Hollins St., Balto., Md.

19. 5/17/48 19. Walter R. Mayer
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17, 1948 2:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 27, 1946 to May 17, 1948

and that I last saw him alive on May 17, 1948

Immediate cause of death Pulmonary Tuberculosis
 DURATION 3 1/2

Due to Tubercle Bacilli
 yrs.

Due to _____
 Other conditions Tuberculous Laryngitis 6 mos.

(Include pregnancy within 3 months of death)

Major findings of operations No operation
 Date of op. _____

Autopsy results No autopsy.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Stewart S. Shaffer M.D.

Address Mt. Wilson, Md. Date signed 5/17/48

RECEIVED
MAY 20 1948
BUREAU V. S.

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year, 28 days

Hospital, institution, or street address where death occurred:

Spring Grove State HospitalHow long in hospital or institution? 1 year, 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 328 South Highland Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Maude M. Tippet

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) March 7, 1870
6.(c) If alive, give age years

8. AGE: Years 78 Months 2 Days 6 If less than one day
.....hrs.min.

9. Birthplace Harrisburg, Pennsylvania
(Town, county, and state)

10. Usual occupation Exchange clerk11. Industry or business Store12. Name Robert Tippet13. Birthplace London14. Maiden name Mary ??15. Birthplace Wales16. Informant Hospital recordsAddress Catonsville 28, Maryland

17. Burial Date thereof May 17th
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Parkwood CemLocation Rural18. Funeral director Willrich Funeral HomeAddress 2008 Orleans St

19. 5/17 1948 Dr. Wedel
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1948 at 8:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
April 15 1947 to May 13 1948

and that I last saw him alive on May 13 1948

Immediate cause of death Left broncho pneumonia DURATION 5 days

Due to Arteriosclerotic cardiovascular disease indefinite

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Isadore Tuerk, M.D. M. D. or otherAddress Catonsville 28, Md. Date signed 5/13/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Life expect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 38 Days
 Hospital, institution, or street address where death occurred:
Vets. Adm. Hospital, Ft. Howard, Maryland
 How long in hospital or institution? 38 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1561 Leslie Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war VV-I

3. (a) FULL NAME

GOLDIE TOYER

3. (b) Social Security Number

Unknown

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Widower
 6.(b) Name of husband or wife _____
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) 8-14-1896
 8. AGE: Years 51 Months 9 Days 13 If less than one day _____ hrs. _____ min.

9. Birthplace St. Mary's County, Md.
 (Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business _____

FATHER 12. Name William Toyer
 13. Birthplace St. Mary's County, Md.

MOTHER 14. Maiden name Lucy Chase
 15. Birthplace St. Mary's County, Md.

16. Informant Clinical Records, Vets. Adm. Hosp.
Fort Howard, Maryland
 Address _____

17. Burial Date thereof 6-1-48
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Baltimore National Cemetery
Baltimore, Md.
 Location _____

18. Funeral director Kelson Funeral Home
 Address 1303 Presstman St., Balto., Md.

19. 6/1 48 Dr. Hedrick
 (Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27, 1948, at 10:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19, 1948, to May 27, 1948, and that I last saw him alive on May 27, 1948.

Immediate cause of death Squamous cell carcinoma of esophagus 3 Mos. plus.

Due to _____

Due to _____

Other conditions Pathologic fracture of rt. femur 2 days

(Include pregnancy within 3 months of death)

Major findings of operations Bronchoscopy, esophagoscopy and biopsy Date of op. 4-28-48

Autopsy results No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J.B. Dukes M.D. M. D. or other

Address V.A.H., Ft. Howard, Md. Date signed 5-28-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04803

Reg. Dist. No.

44

1. PLACE OF DEATH:

County BaltimoreCity or town Chase
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 yr.

Hospital, institution, or street address where death occurred:

Eastern Ave. Extended

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Chase
(If outside city or town limits, write RURAL and give nearest town)Street No. Eastern Ave. Extended
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

ARVID VINCENT

3. (b) Social Security Number

**

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed6. (b) Name of husband or wife Kathleen Ives Vincent

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Sept. 29th, 18778. AGE: Years 70 Months 7 Days 15 If less than one day
..... hrs. min.9. Birthplace Sweden
(Town, county, and state)

10. Usual occupation

11. Industry or business Retired12. Name Unknown13. Birthplace Unknown14. Maiden name Unknown15. Birthplace Unknown16. Informant Mr. Arvid Ives VincentAddress Eastern Ave. Extended, Chase, Md.17. Burial Date thereof May 17, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory ParkwoodLocation Balto., Md.18. Funeral director Lassahn Funeral HomeAddress 7401 Belair Road19. May 15 1948 John H. Grunelf
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14th, 1948 at 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 13th 1948 to May 14th 1948
and that I last saw him alive on May 14th 1948

Immediate cause of death

DURATION

Carcinoma of Stomach 4 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations no

Date of op.

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

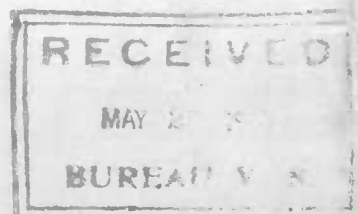
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James G. White M.D. M. D. or other422 Eastern Ave Address Baltimore, Md. Date signed 5/15/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 37

04894

552

1. PLACE OF DEATH:

County BaltimoreCity or town Texas
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 yr. 9 mo. 19 da

Hospital, institution, or street address where death occurred:

Baltimore County HomeHow long in hospital or institution? 4 yr. 9 mo. 19 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Woodlawn
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Steve Wagner

3. (b) Social Security Number

C

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

—6. (b) Name of husband or wife Margaret Richey Wagner

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) July 11, 18878. AGE: Years 60 Months 9 Days 25 It less than one day _____ hrs. _____ min.9. Birthplace Barton, Maryland
(Town, county, and state)10. Usual occupation Engineer

11. Industry or business _____

12. Name John Wagner13. Birthplace Maryland14. Maiden name Mayer Magruder15. Birthplace Maryland18. Informant Baltimore County Home RegistrarAddress Texas, Maryland17. Removal Date thereof May 7 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Oak Hill Cem.Location Lonaconing Md.18. Funeral director M. Eichman & SonsAddress Lonaconing Md.19. May 6 18 48 M. J. Ghilardi
(Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 19 48, at 9 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16 19 48 to May 5 19 48and that I last saw him alive on May 5 19 48Immediate cause of death Carcinoma -
(Adeno pharyngeal)

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Wilmer C. Emmer M.D.Address Cochranville Md. Date signed 5/6/48

M. D. or other _____

RECEIVED

MAY 12 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

04805

1. PLACE OF DEATH:

County BaltimoreCity or town Essex, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Henry Warrick.

3. (b) Social Security Number

4. Sex

M

5. Color or race

White

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

Ressie F. (Coakley)

7. Birth date of deceased (mo., day, yr.)

Sept. 23 - 1902

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

if less than one day

45820

.....hrs.min.

9. Birthplace

Garrett Co. Md.
(Town, county, and state)

10. Usual occupation

Shearman

11. Industry or business

Pharm Manufacturing Co.
Bonsi Warrick

FATHER

12. Name

Bonsi Warrick

13. Birthplace

Md.

MOTHER

14. Maiden name

Clarisa L. Beaver

15. Birthplace

Md.

16. Informant

Charles E. Warrick

Address

Cumberland, Md.

17. (Burial, cremation, or removal, Which?)

Removal

Date thereof

May - 4 - 1948
(month) (day) (year)

Cemetery or crematory

Mt. Airy, Md.

Location

Reston, Virginia

18. Funeral director

John P. Connolly

Address

418 Eastern Ave.

19.

May 4th 1948
(Date, as registered by registrar)John P. Connolly
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Balts.

City or town

Essex
(If outside city or town limits, write RURAL and give nearest town)

Street No.

Louane Ave.
(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 3

19

48, at 90 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw him..... alive on

19

Immediate cause of death

DURATION

Coronary Occlusion

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

Home
(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

W. B. Davis, M.D.
Wp. Res. Exam. / Baltimore
5/3/48

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04806

940

Reg. Dist. No. 41

1. PLACE OF DEATH:

County... BaltimoreCity or town... 104 Walnut Ave Dundalk
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

James Watson

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Widower

6. (b) Name of husband or wife

Lizzie McCloy Watson

7. Birth date of

deceased (mo., day, yr.)

May 3, 1903

6. (c) If alive, give age... years

8. AGE:

Years

45

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Appomattox County Va.
(Town, county, and state)

10. Usual occupation

Unemployed

11. Industry or business

FATHER

12. Name

Geo Watson

13. Birthplace

Va

14. Maiden name

Maei Gough

15. Birthplace

Va.

16. Informant

Julian Watson

Address

131 Oak St

17. Burial

(Burial, cremation, or removal. Which?)

mt. Orono Cem

Cemetery or crematory

Location A. A. County

18. Funeral director

Mrs. Ruth G. Elliott, Dundalk

Address

1129 N. Caroline St.

19. 5/18 45

(Date rec'd by registrar)

19.

Date

A. P. Hedrick

Registrar

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md.County... BaltimoreCity or town... Dundalk

(If outside city or town limits, write RURAL and give nearest town)

Street No. 104 Walnut Ave

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH... May 15, 1948, at 1:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 13, 1948 to May 15, 1948and that I last saw him... alive on May 15, 1948Immediate cause of death Coronary Thrombosis

DURATION

26 hrs.

Due to

Due to

Other conditions

Bronchial Pneumonia

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

William S. Spade, M.D.

M. D. or other

Address... 140 Oak AveDate signed 5-15-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04807 33

1. PLACE OF DEATH:

County Baltimore
 City or town Owings Mills, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 11/7/46 to 5/28/48
 Hospital, institution, or street address where death occurred:
Rosewood State Training School.
 How long in hospital or institution? 11/8/46 to 5/28/48

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Owings Mills, Baltimore City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1772 Homestead Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

Paul Smith Wernig.

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
 B.(b) Name of husband or wife _____
 B.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) October 18, 1938
 8. AGE: Years 9 Months 7 Days 10 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Md.
 (Town, county, and state)
 10. Usual occupation Inmate- Rosewood

11. Industry or business

FATHER 12. Name William Charles Wernig
 13. Birthplace Baltimore, Md.

MOTHER 14. Maiden name Elizabeth R. Smith
 15. Birthplace Baltimore, Md.

16. Informant Institutional records.
 Address Rosewood, Owings Mills, Md.

17. Burial Date thereof June 1, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Holy Redeemer
 Location Belair Rd. Balto: Md.

18. Funeral director Geo J. Ruth Inc. BDM
 Address 1735- Harford Ave

19. 6/1 19 48 A.W. Hedlund
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH May 28 19 48, at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Nov. 7 19 46 to May 28 19 48
 and that I last saw him alive on May 28 19 48

Immediate cause of death Status Epilepticus DURATION 10 min.

Due to Post encephalitis with symptomatic epilepsy. Infancy

Due to Grand- Mal type

Other conditions Childhood T.P. arrested 2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE H.S. Butler M. D. or other
H.C. Butler,
 Address Owings Mills Date signed 5/28/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

117a

04808

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:

County BaltimoreCity or town Oakland Mills
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County CarrollCity or town Greenville
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

James E. White

3. (b) Social Security Number

817-01-13334. Sex Male 5. Color or race W 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Annie E. White7. Birth date of deceased (mo., day, yr.) January 16 1887 6. (c) If alive, give age _____ years8. AGE: Years 61 Months 4 Days 2 If less than one day _____ hrs. _____ min.9. Birthplace Maryland
(Town, county and state)10. Usual occupation Fertile Worker

11. Industry or business

12. Name Al White13. Birthplace Maryland14. Maiden name Anna Beecraft15. Birthplace Maryland16. Informant Mrs Annie E WhiteAddress Greenville, Md.17. Burial Date thereof May 21 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Oakland MillsLocation Oakland Mills18. Funeral director C. H. GreenAddress Greenville, Md.19. 5/18/48 Wm E. Mantey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 1948 at 2 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-16-48 1948 to 12-6-47 1947
and that I last saw him alive on 12-6-47 1947Immediate cause of death Angina PectorisDURATION
6 mo.

Due to _____

Due to _____

Other conditions Chr. Gastric ulcer 3 yrs
Arteriosclerosis 3 yrs
(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

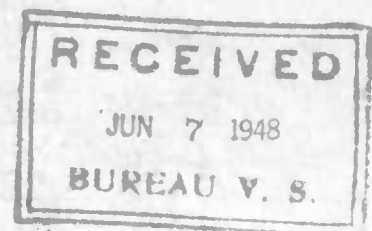
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Dr. D. D. Caples Med. Exam.
Address Registration, Md. M. D. or other _____
Date signed 5-19-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 35-

1. PLACE OF DEATH:

County Baltimore
 City or town Rural near Parkton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 yrs.
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Rural near Parkton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1 mi. South of Parkton
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

George Henry Wilhelm

3. (b) Social Security Number

2-006-059

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Kate Wilhelm

7. Birth date of

deceased (mo., day, yr.) September 12, 18726. (c) If alive, give age 85 years

8. AGE:

Years

Months

Days

If less than one day

75816

hrs.

min.

9. Birthplace

Freeland, Md.

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

Engineer

FATHER

12. Name

Daniel Kirk Wilhelm

13. Birthplace

Balto., Co., Md.

MOTHER

14. Maiden name

Eliza Kirk

15. Birthplace

Balto., Co., Md.

16. Informant

Mrs. Kate Wilhelm

Address

Parkton, Md. R.D.

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

June 1, 1948

(month) (day) (year)

Cemetery or crematory

Mt. Zion Cem.

Location

Freeland, Balto. Co., Md.

18. Funeral director

Jacob Hartenstein

Address

New Freedom Co.

19. May 30

(Date rec'd by registrar)

19 48

Charles E. Grier

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28, 19 48 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 48 to May 28, 19 48and that I last saw him alive on May 27, 19 48

Immediate cause of death

Cardio-Vascular
renal disease

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

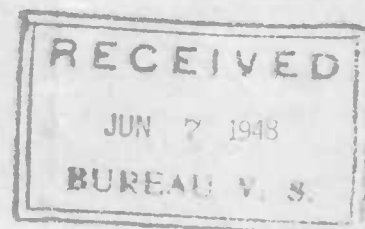
23. SIGNATURE

A. M. France

M. D. or other

Address

Parkton, Md.Date signed 5/28/48



Evidence for change of MARYLAND STATE DEPARTMENT OF HEALTH
age shown on:
FLM No. G 110 MAY 27 1948 CERTIFICATE OF DEATH

2411 N. Charles St., Baltimore

04810

Reg. Diat. No. 37

1. PLACE OF DEATH

County Baltimore
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Sparks
(If outside city or town limits, write RURAL and give nearest town)
Street No. Falls Rd.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Lewis Milford Wilhelm

3. (b) Social Security Number

217-07-8013

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Leona Naylor

7. Birth date of deceased (mo., day, yr.) Aug. 4, 1907 1912 6. (c) If alive, give age 37 years

8. AGE: Years 35 Months 9 Days 16 It less than one day hrs. min.

9. Birthplace Balto Co. Md.
(Town, county, and state)

10. Usual occupation carpenter

11. Industry or business

12. Name Irwin T. Wilhelm

13. Birthplace Balto. Co. Md.

14. Maiden name Grace Harris

15. Birthplace Balto. Co. Md.

16. Informant Mrs. Lewis M. Wilhelm

Address Sparks, Md.

17. Burial Date thereof 5-23-48
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Falls Rd. Chapel

Location Sparks, Md.

18. Funeral director Judson M. Brooks

Address Sparks, Md.

May 22, 48 Wilmer C. Ensor

19. (Date rec'd by registrar) 19 48 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 48 at 2:00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw alive on 19

Immediate cause of death Drowning DURATION inst.

(Accidental)

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accidental Date of 5/20/48

Where did injury occur? Baltimore Balto Md
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Falls in creek.

Means of injury Injured at work?

23. SIGNATURE John S. Green M. D. or other

Address Lewiston - 4 - Md. Date signed 5/21/48

MARGIN RESERVED FOR BINDING

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County BaltimoreCity or town Rural
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Rural near Freeland
(If outside city or town limits, write RURAL and give nearest town)Street No. 2 mi S.W. of Freeland
(If rural, give LOCATION)

2. (a) If veteran, name war:

3. (a) FULL NAME

Marian Patricia Wilson

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

B. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife:

7. Birth date of deceased (mo., day, yr.) May 27, 1948

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

3

hrs.

min.

9. Birthplace

Freeland, Md. R.D.
(Town, county, and state)

10. Usual occupation:

11. Industry or business

FATHER

12. Name

J. Franklin Wilson

MOTHER

13. Birthplace

Parkton, Md. R.D.

14. Maiden name

Blanche Esther Bell

15. Birthplace

Parkton, Md.

16. Informant

J. Franklin Wilson

Address

Freeland, Md. R.D.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

May 31, 1948
(month) (day) (year)

Cemetery or crematory

Pine Grove, B. Cem.

Location

Parkton, Md. R.D.

18. Funeral director

John H. Haysen

Address

New Freedom, Pa.

19. May 30

(Date read by registrar)

1948

Charles E. Fiedler
Reg.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30, 1948 at 3:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19..... to.....19.....
and that I last saw her alive on May 29, 1948

Immediate cause of death

Prematurity

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

A. M. France

M. D. or other

Address Parkton, Md. Date signed 07/30/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 7 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, IN INK, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04812

Evidence for change of

age shown on:

HLA No. G 116 JUN -7 1948

CERTIFICATE OF DEATH

93d

Reg. Dist. No. 4/0

1. PLACE OF DEATH:

County Baltimore
 City or town Outside of Baldwin
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Baltimore
 City or town outside of Baldwin
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Howard Mitchell Woodrow4. Sex male 5. Color or race white 6. (d) Single, married, widowed, or divorced widowed6. (b) Name of husband or wife Lillie Mae Woodrow

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Oct. 4, 18848. AGE: Years 63 Months 6 Days 21 If less than one day _____ hrs. _____ min.8. Birthplace Cecil County
(Town, county, and state)10. Usual occupation Farming

11. Industry or business _____

12. Name James Woodrow13. Birthplace Cecil County, Md.14. Maiden name Margaret Warren15. Birthplace Cecil County16. Informant Lula Mae LoganAddress Baldwin, Md.17. Burial Date thereof May 27, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematorium HopewellLocation Post Deposit Md.18. Funeral director E. F. FylerAddress Rising Sun Md.19. May 27 19 48 G. E. Arthur
(Date rec'd by registrar) (year) (month) (day) Registrar

3. (b) Social Security Number _____

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 19 48 at 5:10 P.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 8, 19 47 to May 25 19 48 and that I last saw him alive on May 24, 19 48Immediate cause of death congestive Heart Failure DURATION 3 MOS.Due to Hypertensive Cardiovascular Disease 6 MOS.

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Clifford F. Hudson M.D. M. D. or other _____Address Lark Md Date signed 5/25/48

RECEIVED

MAY 29 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

04813
32

1. PLACE OF DEATH:

County BALTIMORECity or town STEVENSON
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 yrs.Hospital, institution, or street address where death occurred: —How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County BALTIMORECity or town STEVENSON
(If outside city or town limits, write RURAL and give nearest town)Street No. HILLSIDE ROAD
(If rural, give LOCATION)2.(a) If veteran, name war —

3. (a) FULL NAME

MARY ELLIS ZENTZ

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

MARRIED6. (b) Name of husband or wife WILLIAM FREDERICK ZENTZ7. Birth date of deceased (mo., day, yr.) FEB 5-19036. (c) If alive, give age 57 years

8. AGE:

Years

Months

Days

If less than one day

4539

hrs.

min.

8. Birthplace HOWARD Co., Md.
(Town, county, and state)10. Usual occupation HOUSEWIFE

ff. Industry or business

FATHER

12. Name JOHN DAY13. Birthplace HOWARD Co., Md.

MOTHER

14. Maiden name SALLIE REESE15. Birthplace HOWARD Co., Md.18. Informant WM F. ZENTZAddress HILLSIDE Rd. STEVENSON, Md17. BURIAL Date thereof MAY 17, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Druid RidgeLocation PIKESVILLE, Md.18. Funeral director Frank H. NewellAddress Pikesville, Md.19. 5-17-48 Dr E E Nichols
(Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 14 19 48, at 11:52 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 17 January 19 48, to 14 May 19 48, and that I last saw him alive on 14 May 19 48.Immediate cause of death Carcinomatosis

DURATION

Due to generalized -Due to Primary site unknown
6/25/48Other conditions —

(Include pregnancy within 8 months of death)

Major findings of operations —Date of op. —Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —Where did injury occur? —
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) —Means of injury — Injured at work? —23. SIGNATURE Charles H. Williams M.D.
M. D. or otherAddress Pikesville 8, Md. Date signed 14 May 1948

MASSACHUSETTS DEPARTMENT OF JUSTICE

INVESTIGATION OF DEATH

STATE OF MASSACHUSETTS

INVESTIGATION OF DEATH

RECEIVED

MAY 18 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 38

I. PLACE OF DEATH:

County Baltimore
City or town Stonleigh
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 516 Dunkirk Rd
Stay in hospital or inst. (yrs., or mos., or days) _____
Stay in this community (yrs., or mos., or days) 20 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md County Balt.
City or town Stonleigh Ward No. _____
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 516 Dunkirk Rd
(If rural give LOCATION)
2(c) IF VETERAN, NAME WAR _____

3. (a) FULL NAME

Elizabeth A. Boone

3. (b) Social Security Number

4. Sex F 5. Color of face W 6. (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Jacob C. Boone

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Oct. 8, 1853
8. AGE: Years 94 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Maryland
(town, county, and state)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER 12. Name John Boenzli

13. Birthplace Switzerland

14. Maiden name Mary E. Eckert

15. Birthplace Germany

16. Informant George J. Boone

Address 516 Dunkirk Rd. Stonleigh 12

17. Burial Date thereof 5-14-48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Woodlawn

Location _____

18. Funeral director John A. Moran

Address 3000 E. Balt. St.

19. May 13, 1948 Registrar G. J. Redneck
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 19 48 at 5:50 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 6 19 48 to May 11 19 48, and that I last saw her alive on May 11 19 48.

Immediate cause of death Pulmonary Edema DURATION 3 hrs.

Due to Chronic Myocarditis 2 yrs.

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE M. G. Gale M. D. or other _____

Address 6014 York Road Date signed 5-11-48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.